

The Stop TB Partnership In South Africa

A Review



2004

03937

8937

Community Health Cell

Library and Information Centre

367, "Srinivasa Nilaya"

Jakkasandra 1st Main,

1st Block, Koramangala,

BANGALORE - 560 034.

Phone : 553 15 18 / 552 53 72

e-mail : chc@sochara.org

THE STOP TB PARTNERSHIP IN SOUTH AFRICA

A REVIEW

Written by:

David Barr, Ashnie Padarath, Lynette Sait

This publication is also available on the internet
www.hst.org.za

2004

Suggested citation:

Barr D, Padarath A, Sait L. "The Stop TB Partnership in South Africa - A review." Durban: Health Systems Trust; 2005.

Acknowledgements: Antoinette Ntuli - HST
Jose Utrera - WEMOS
Funded by WEMOS



Published by Health Systems Trust

Health Systems Trust
401 Maritime House
Salmon Grove
Victoria Embankment
Durban 4001
Tel: 031 - 307 2954
Fax: 031 - 304 0775
Email: hst@hst.org.za
Web: <http://www.hst.org.za>



The information contained in this publication may be freely distributed and reproduced, as long as the source is acknowledged, and it is used for non-commercial purposes.

THE STOP TB PARTNERSHIP IN SOUTH AFRICA

A REVIEW

2001



DIS-319
03937 p04

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CDC	Centers for Disease Control and Prevention
DEWG	Dots Expansion Working Group
DFID	Department for International Development
DOT	Directly Observed Treatment
DOTS	Directly Observed Short Course Strategy
GDG	Global Drug Fund
GLC	Green Light Committee
GPG	Global Public Good
GPPI	Global Public Private Initiatives
GPSTB	Global Plan to Stop Tuberculosis
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IUATLD	International Union Against Tuberculosis and Lung Disease
KNCV	Royal Netherlands Chemical Society
MDR-TB	Multi-Drug Resistance Tuberculosis
MTDP	Medium Term Development Programme
MRC	Medical Research Council
NICC	National Inter-Agency Co-ordinating Committee
NTCP	National Tuberculosis Control Programme
PHC	Primary Health Care
SADC	Southern African Development Community
SANTA	South African National Tuberculosis Association
STB	Stop Tuberculosis (Partnership)
TA	Technical Assistance
TADSA	TB Alliance DOTS Support Association
TB	Tuberculosis
TBCTA	TB Coalition for Technical Assistance
UN	United Nations
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary Testing and Counselling
WHO	World Health Organization

1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10	10
11	11
12	12
13	13
14	14
15	15
16	16
17	17
18	18
19	19
20	20
21	21
22	22
23	23
24	24
25	25
26	26
27	27
28	28
29	29
30	30
31	31
32	32
33	33
34	34
35	35
36	36
37	37
38	38
39	39
40	40
41	41
42	42
43	43
44	44
45	45
46	46
47	47
48	48
49	49
50	50
51	51
52	52
53	53
54	54
55	55
56	56
57	57
58	58
59	59
60	60
61	61
62	62
63	63
64	64
65	65
66	66
67	67
68	68
69	69
70	70
71	71
72	72
73	73
74	74
75	75
76	76
77	77
78	78
79	79
80	80
81	81
82	82
83	83
84	84
85	85
86	86
87	87
88	88
89	89
90	90
91	91
92	92
93	93
94	94
95	95
96	96
97	97
98	98
99	99
100	100

TABLE OF CONTENTS

List of Acronyms

Table of Contents

Executive Summary	1
Introduction	4
Methodology	5
Global public private partnerships in health	6
South Africa in context	8
Human rights and equity	9
Key indicators	11
The South African health system	12
Health care financing and human resources	13
Tuberculosis in South Africa	15
The National TB Control Programme	18
The Stop TB Partnership	27
The structure of the Partnership	28
The Stop TB Partnership in South Africa	31
1 International partners	31
2 National partnership	36
3 Working groups	43
4 Advocacy	52
Findings and Recommendations	55
References	59

1	Introduction
2	The role of theory
3	The role of research
4	The role of practice
5	The role of evaluation
6	The role of ethics
7	The role of culture
8	The role of diversity
9	The role of community
10	The role of the individual
11	The role of the family
12	The role of the social network
13	The role of the environment
14	The role of the healthcare system
15	The role of the legal system
16	The role of the media
17	The role of the economy
18	The role of the politics
19	The role of the religion
20	The role of the philosophy
21	The role of the science
22	The role of the art
23	The role of the literature
24	The role of the music
25	The role of the dance
26	The role of the drama
27	The role of the film
28	The role of the television
29	The role of the internet
30	The role of the mobile phone
31	The role of the social media
32	The role of the video game
33	The role of the computer
34	The role of the robot
35	The role of the artificial intelligence
36	The role of the nanotechnology
37	The role of the biotechnology
38	The role of the space technology
39	The role of the environmental technology
40	The role of the energy technology
41	The role of the information technology
42	The role of the communication technology
43	The role of the transportation technology
44	The role of the construction technology
45	The role of the manufacturing technology
46	The role of the agriculture technology
47	The role of the fishing technology
48	The role of the mining technology
49	The role of the forestry technology
50	The role of the aquaculture technology
51	The role of the viticulture technology
52	The role of the horticulture technology
53	The role of the silviculture technology
54	The role of the apiculture technology
55	The role of the pisciculture technology
56	The role of the aviculture technology
57	The role of the sericulture technology
58	The role of the apiculture technology
59	The role of the pisciculture technology
60	The role of the aviculture technology
61	The role of the sericulture technology
62	The role of the apiculture technology
63	The role of the pisciculture technology
64	The role of the aviculture technology
65	The role of the sericulture technology
66	The role of the apiculture technology
67	The role of the pisciculture technology
68	The role of the aviculture technology
69	The role of the sericulture technology
70	The role of the apiculture technology
71	The role of the pisciculture technology
72	The role of the aviculture technology
73	The role of the sericulture technology
74	The role of the apiculture technology
75	The role of the pisciculture technology
76	The role of the aviculture technology
77	The role of the sericulture technology
78	The role of the apiculture technology
79	The role of the pisciculture technology
80	The role of the aviculture technology
81	The role of the sericulture technology
82	The role of the apiculture technology
83	The role of the pisciculture technology
84	The role of the aviculture technology
85	The role of the sericulture technology
86	The role of the apiculture technology
87	The role of the pisciculture technology
88	The role of the aviculture technology
89	The role of the sericulture technology
90	The role of the apiculture technology
91	The role of the pisciculture technology
92	The role of the aviculture technology
93	The role of the sericulture technology
94	The role of the apiculture technology
95	The role of the pisciculture technology
96	The role of the aviculture technology
97	The role of the sericulture technology
98	The role of the apiculture technology
99	The role of the pisciculture technology
100	The role of the aviculture technology

EXECUTIVE SUMMARY

This review of the Stop TB Partnership in South Africa is part of a multi- country study funded by WEMOS. The review seeks to augment the existing body of knowledge on Global Public Private Initiatives (GPPIs) in Health with the aim of generating a set of country-based evidence relating to the effect of GPPIs on health policies and health systems.

Global Public Private Partnerships, are defined by Buse and Walt as “a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour”.

The role of GPPIs has been questioned with regard to their impact on the traditional role of the state and public institutions in society, with the assertion that such arrangements provide nation states with the possibility of reneging on their obligation to promote and protect the health of their citizens. Buse and Waxman caution that these partnerships could “legitimise the withdrawal of social safety nets resulting in the benefits of partnerships being restricted to islands of excellence in seas of under provision, while seemingly exonerating public authorities from blame for breaching the social contract’.

Data for this report was gathered from several sources including unpublished documentary papers on the control of TB in South Africa, the management of external resources for health, the human rights approach to health, and on Global Public-Private-Partnerships and the Stop TB Partnership. The Stop TB Partnership website was used extensively, as was Institute for Health Sector Development’s (IHSD) independent evaluation of the Stop TB Partnership. Databases were also used including that of the Initiative on Public-Private Partnerships for Health.

The Stop TB Partnership is a global movement comprising global partnerships to accelerate social and political action to halt the spread of tuberculosis around the world. The Partnership is not a legal entity, but a “group of entities working with a common goal”. The Stop TB Partnership describes its approach as a co-ordinated, multi-national, multi-sectoral effort to control TB.

The structure of the Partnership includes the Partners’ Forum, the Co-ordinating Board, the Secretariat and seven working groups.

The mission of the Stop TB Partnership is to increase access, security and support to:

- ensure that patients have access to effective diagnosis, treatment and cure to stop transmission of TB;
- reduce the economic toll of TB; and to
- develop and implement new preventive, diagnosis and therapeutic tools and strategies to Stop TB.

This report asks what impact the Stop TB Partnership has had in South Africa.

The impact of the Stop TB Partnership has been mixed. While there is some evidence of increased political commitment and sustained advocacy initiatives linked to the Partnership, there are many areas where the impact has been less than optimal.

In assessing the impact on how international partners are operating in South Africa, it was found that the Partnership has added value to some technical agencies operating in South Africa. For example, the Partnership has been credited with facilitating a more co-ordinated way of working, avoiding duplications and making use of the additional competencies of each of the partnerships. Some respondents pointed out that the development of an MTDP through a consultative process and offering a framework within which all partners could work, is in itself strong evidence of extra co-ordination facilitated by the Stop TB Partnership.

Additionally, the Stop TB Partnership has also successfully increased political commitment to TB control and DOTS at a both national and provincial levels, although this impact is difficult to quantify or disaggregate from other political events.

The development of generic guidelines has also reportedly been of some assistance to the South African NTCP- as have annual meetings such as those for the DOTS Expansion Working Group which allow partners a forum to discuss TB control in South Africa.

The study shows that access to effective diagnosis and treatment and considerations of equity (part of the mission and values of the partnership) are critical issues in South Africa, and have not been addressed by the Partnership.

It has been difficult to link the creation of the Stop TB Partnership with increased technical assistance in South Africa. Firstly, all international agencies operating in South African TB control were active in the country before the initiation of the Stop TB Partnership, and there has been a continuous stream of international support since the early 1990s.

The following recommendations to the Partnership are pertinent:

A rights-based approach to the problem must be adopted which includes the active, meaningful and free participation of individuals who are affected by the issue. Any attempt to curb, control and treat TB must recognise the disease as a social, economic and political one and not purely a medical problem.

Effective TB control and treatment efforts will not survive or flourish in an environment where insufficient attention is paid to the broader underlying socio-economic determinants of health. Some of the structural factors that contribute to the flourishing of the disease include poverty and economic underdevelopment which is frequently expressed in inequities and uneven health outcomes. A development approach to addressing TB would then seek to address system-related factors that underline general ill health such as poverty and gender inequities. The high levels of TB and HIV co-infection also pose formidable challenges to TB control in the country.

Although the Stop TB Partnership has a central website, it was very difficult to obtain information on the partnership at country level. Knowledge of the Partnership seems to be confined to a few key people. Several relevant documents are not in the public domain.

Although the Partnership has support at national government level, politicians who are considered to be co-drivers of policy are not well informed about the aims and objectives and the activities that underpin the Partnership. This gap has the potential to weaken the Partnership and must be addressed.

An appropriate response to TB constitutes more than just procuring drugs and upgrading existing infrastructure. A complex set of geopolitical, medical, social and financial factors need to be aligned to produce a fair, sustainable and humanitarian response.

INTRODUCTION

This case study presents an overview of the Stop TB Partnership operating in the South African context. It offers an analysis of the activities and impact of the Partnership in South Africa. Its overarching objective is to collect a set of baseline data on the functioning and operational aspects of the Partnership and to assess whether such initiatives contribute to the development of equitable health services in the public health sector.

Tuberculosis is a priority disease in South Africa: the cure rate for new patients of 64% is still way below the World Health Organization (WHO) target of 85%. In some provinces, the cure rate is as low as 40%. The estimated incidence of TB per 100 000 population is 526, and an estimated 60% of adults with TB are also HIV positive. South Africa is ranked third in the WHO AFRO region by the number of TB cases, and ninth globally.

Funded by WEMOS, this review is part of a multi-country study. It aims to augment the existing body of knowledge on Global Public Private Initiatives in Health (GPPIs) and to generate a body of country-based evidence relating to the effect of GPPIs on health policies and health systems.

METHODOLOGY

Data for this report was gathered from several sources including unpublished documentary papers on the control of TB in South Africa, the management of external resources for health, the human rights approach to health, and on Global Public-Private-Partnerships and the Stop TB Partnership (Stop TB Partnership). The Stop TB Partnership website was used extensively, as was Institute for Health Sector Development's (IHSD) independent evaluation of the Stop TB Partnership. Databases were also used including that of the Initiative on Public-Private Partnerships for Health.

Discussion on the Stop TB Partnership in South Africa is based largely on a series of key informant interviews (n=13). These interviews were semi-structured to cover a range of topics and questions which were made relevant to the informants' background. Interviews were performed by a variety of means: face-to-face interviews with audio recording and transcription by two researchers (n=2); telephone interviews with handwritten note-taking and subsequent review/validation of these notes with the informant (n=5); and email questionnaires (n=6). Informants were identified by a variety of means including through the web-based Stop TB Partners' Directory, the Stop TB documentation review and by means of the 'snow ball' technique. Key informants included members of the Stop TB Secretariat, academics, staff from the National TB Control Programme and national and international partners and technical agencies.

GLOBAL PUBLIC PRIVATE PARTNERSHIPS IN HEALTH

Globalisation has been described as “both a slogan and a useful historical and analytic concept”.¹ The meaning and impact of globalisation are contested issues. While some argue that it is an “inescapable and primarily benign process of global economic integration in which countries drop border restrictions on the flow of capital, goods and services”, others contend that the globalisation phenomenon is synonymous with a “technologically mediated coup by economic elites and political conservatives to create a new world order based more on private corporate control than public democracy”.¹

Globalisation intersects with international health in many ways. At the most obvious level, the relative reduction in costs of transport has facilitated an “increase in the extent, intensity and velocity of flows of people and pathogens”.² At a more profound level, in keeping with the development of new economic winners and losers, globalisation has also created new winners and losers in the global health sector.

Globalisation has also contributed to the development of Global Public Private Initiatives (GPPIs). These have been defined as “a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organisation, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour”.³

The advent of GPPIs in health had its genesis in the 1993 World Health Assembly call to the World Health Organization (WHO) to “mobilise and encourage the support of all partners in health development, including non-governmental organisations and institutions in the private sector, in the implementation of national strategies for health for all”.⁴ The WHO’s subsequent corporate strategy lists partnerships as one way in which to achieve health for all.

Questions have been raised regarding the desirability, sustainability, effectiveness and impact of such partnerships. Attention has been given to assessing how far GPPIs strengthen the right to health in countries where their activities are located, the appropriateness of these interventions and the effect of such initiatives on the overall health system. In addition, while GPPIs may provide high profile publicity for corporate companies (in the form of branding and creating an image of corporate social responsibility), the agendas of such companies are not always clearly articulated. Moreover disentangling the commercial interests of corporates from the interests of the GPPIs can be difficult. This has given rise to concerns about the exertion of a possible undue influence in the public policy-making domain.

However, Widdus, writing for the WHO Bulletin, points out that the rationale for public-private partnerships is not about accessing money from profit-making enterprises or facilitating the intrusion of business into the public policy domain, but about combining different expertise, skills and other resources to achieve a common goal that is not attainable by independent action alone.⁵

The role of partnerships has also been questioned with regard to their impact on the traditional role of the state and public institutions in society, with the assertion that such arrangements provide nation states with the possibility of reneging on their obligation to promote and protect the health of their citizens. Buse and Waxman caution that these partnerships could “legitimise the withdrawal of social safety nets resulting in the benefits of partnerships being restricted to islands of excellence in seas of under provision, while seemingly exonerating public authorities from blame for breaching the social contract.”⁴

At the global level, concerns have been raised that the United Nations could be vulnerable to “institutional capture” by more powerful partners, leading to partial privatisation and commercialisation of the UN system.

The recognition of infection control as a global public good (GPG) has further contributed to the increase of GPPIs in the last few years. As Labonte *et al* point out: “Despite some disagreement, ... a consensus is emerging that the fight against infectious diseases affecting poorer countries is both a GPG in itself and requires important investments in GPGs that are beyond the means or incentives of any single government and beyond the capabilities of national level programs”.¹ Many have argued that this is indeed a moral imperative.

It has been suggested that governance of GPPIs plays a critical role in ensuring and maintaining a level playing field. According to Buse, the following criteria can be used to assess governance in GPPIs:

- legitimacy or the extent to which the authority of the GPPI is considered valid;
- representation and participation;
- the extent to which those vested with authority can be held responsible for their decisions and actions;
- transparency;
- effectiveness, efficiency and sustainability.⁶

SOUTH AFRICA IN CONTEXT

After years of institutionalised inequity, South Africa's first democratic government was elected into power in April 1994. The major goal underpinning policy development of the newly elected government was the promotion of equity and eradication of the injustices built up over many years. The scale of the challenge is signalled by the fact that South Africa remains one of the most inequitable countries in the world.⁷

The Gini index, which is a measure of the income inequality for a country is 59.3, where 0 is a state of perfect equality and 100 a state of absolute inequality.⁷ This puts South Africa among the countries with worst income inequalities in the world. The richest 10% of households accrue over 40% of the country's total income, while the poorest 40% of households, constituting 50% of the population, account for only 11% of total income. Therefore while South Africa is categorised as an upper middle-income country, more than half the population lives in poverty.⁸ Some commentators have argued that the post-1994 government's acceptance of a free market ideology has not successfully impacted on these inequities. Rising unemployment rates indicate that the macro-economic strategy may even have exacerbated inequity.

The national unemployment rate in South Africa is 42%, reflecting an increase of 8% from 1996-2001. African people experience the highest level of unemployment in the country at 48%, and whites the lowest at 10%. Women, in particular African women, represent the largest proportion (53%) of the unemployed in South Africa.⁸

South Africa, classified as an upper middle-income country with a gross domestic product (GDP) per capita of (PPP US\$) 11290 in 2001, has a total population of 44.4 million, of which, 57% reside in urban areas. It is one of the countries hardest hit by the HIV/AIDS epidemic. This has resulted in a significant fall in some key indicators such as life expectancy at birth which has fallen from 57 years between 1970-75 to 47 years between 2000-05. Similarly, the human development index (HDI), which measures human development comprehensively from three dimensions of a long and healthy life, knowledge and a decent standard of living, stands at 0.684. HDI increased from 0.66 in 1975 to 0.741 in 1995 but has been declining ever since.⁹

Human rights and equity

Health care in South Africa is conceptualised as a socio-economic right, and as such is constitutionally protected. Other imperatives to respect the right to health are included in the International Covenant on Economic, Social and Cultural Rights (ICESCR). This covenant provides for the “enjoyment of the highest attainable standard of physical and mental health conducive to living a life of dignity”. This suggests that health care facilities, goods and services have to be available in sufficient quantity, must be physically and economically accessible to everyone, must be ethically and culturally acceptable, and must be of a medically appropriate quality.¹⁰

The South African Constitution¹¹ has been internationally acclaimed for its inclusion of a range of justiciable (courts may be approached to enforce these rights if they have been violated or not adequately provided for) socio-economic rights. Included in these rights, which are enshrined in the Bill of Rights, is the right of access to health care. The Constitution provides for access to health care services including reproductive health and emergency services; basic health care for children, and medical services for detained persons and prisoners. If the state is unable to provide for these rights owing to insufficient resources, it is required to take reasonable legislative and other measures to make progress in the realisation of these rights. However, the Constitution does not guarantee the right to health but the right of access to health care services. By contrast the ICESCR refers to the right to the “highest attainable standard of physical and mental health”.

According to section 7(2) of the Constitution, the State is obliged to respect, protect, promote and fulfil all the rights in the Bill of Rights. In the case of the right to health these obligations are defined in General Comment 14¹² and include the following:

The obligation to respect the right, obliges the State to refrain from denying or limiting access to health care services to anyone. The obligation to protect include, inter alia, adopting legislation and other measures to ensure equal access to health care facilities provided by third parties; to ensure that privatization does not constitute a threat to the availability, acceptability and quality of services provided; and to control the marketing of medicines by third parties. The obligation to promote requires the State to disseminate appropriate information; foster research and support people to make informed choices. The obligation to fulfil requires that the State facilitates and implements legislative and other measures in recognition of the right to health and adopts a national health policy with detailed plans on how to realise the right.¹³

Even though South Africa has not ratified the ICESCR, it can be argued that section 39 of the South African Constitution obliges a court, tribunal or other forum to take into account international law when interpreting the Bill of Rights.

In the context of the increasing role of GPPs in the public health sector, it is important to note that the responsibility for providing health care ultimately rests as a state obligation and is an inextricable benefit of citizenship. GPPI intervention has the potential to dilute such rights and obligation and diminish states' responsibilities and legitimacy for taking the necessary steps to promote equity and human and socio-economic rights.

Equity, as defined by the International Society for Equity in Health is "the absence of potentially remediable, systematic differences in one or more aspects of health across socially, economically, demographically, or geographically defined population groups or subgroups". According to EQUINET, seeking equity in health implies "addressing differences in health status that are unnecessary, avoidable and unfair. In Southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region". Equity-motivated interventions should aim to allocate resources preferentially to those with the worst health status (vertical equity), to address the power and ability people and social groups have to make choices over health inputs and their capacity to use these choices towards health. Planning for equity requires identification of groups disadvantaged in terms of health status or utilisation of services.¹⁴

McCoy suggests that an equity approach is different from a 'basic needs approach' or 'poverty approach' which focus on the poor and the disempowered without relating their condition to the rich and the powerful. Equity implies an approach that gives more to those who have little, and less to those who have much. Rather than the allocation of equal shares, equity implies the allocation of fair shares.¹⁵

Critical elements in implementing an equity-related approach to TB treatment include considerations of age, race, gender, employment status and the nature of the work, and whether people live in urban or rural areas. Indicators to this effect may be included in **eligibility criteria and selection procedures.**¹⁴

The provision of free medication in itself does not necessarily result in equitable outcomes. There are a variety of hidden costs associated with accessing care and treatment which must also be considered. Travelling costs, including time taken to get to treatment centres and the distance some are required to travel to treatment centres also exert a strong influence on decisions to take-up and continue with treatment. In one setting in Malawi, for example, where all public health facilities are within six kilometres of the population

and where care is provided free-of-charge at the point of delivery, it was found that on average, patients spent US\$ 13 and lost up to 22 days work accessing a TB diagnosis - while in Zambia average indirect costs related to pre-diagnosis of TB cost households were close to \$27. Additional studies are required in order to clarify the real direct non-treatment (i.e. transport, time off work, loss of productive time) costs to households affected by AIDS and TB in South Africa.¹⁶

Interventions directed to improve the health status of low-income countries, can sometimes be misdirected and result in inequitable outcomes, falling under the general rubric of 'charity'. Corporate philanthropy may focus on the poor but may not be associated with a human rights- or equity-based approach to health.

Key indicators

According to the latest census 2001 figures, Africans make up 78% of the population, whites 10%, coloured people 8.6% and Indians 2.5%.

Both economic and social policies influence the health sector's ability to limit or reverse health inequities within the population. Sustainable health gains therefore, can only be effected within a broader equitable economic and social development context. Differences between groups in health outcomes such as infant mortality rates, are not only a result of the health system's inability to reduce these differences but also a reflection of a broader social and economic environment within which the inequities exist.⁸

South Africa is characterised by a quadruple burden of disease. The toll of infectious disease is exacerbated by a high injury burden, conditions related to underdevelopment and chronic diseases. The country's first national burden of disease study shows that the largest cause of mortality is HIV/AIDS followed by homicide, tuberculosis, road traffic accidents and diarrhoea.¹⁷

After HIV/AIDS (29.8%), cardiovascular disease (16.6%), infectious and parasitic diseases (10.3%), malignant neoplasms (7.5%), intentional injuries (7.0%) and unintentional injuries (5.4%) are the leading cause of death. Females have higher proportions of deaths through HIV/AIDS and cardiovascular diseases than males while males have a higher proportion of injury deaths.¹⁸

There has been an alarming rise in infant mortality rates. This is linked to the high number of HIV infections in country. Nationally the number of deaths in one-year-old infants per 1 000 live births rose from 45 to 59 between 1998 and 2002.¹⁹ The maternal mortality ratio has averaged 150 per 100 000 live births and life expectancy

as calculated by the UNDP for 2000 was 52 years.⁷ The under-five mortality rate is 95 per 1 000 live births. Stunting has remained constant at 23% for the period 1994–1999– the WHO rate is 20%.⁸

African communities still experience the least access to basic facilities. Thirty-nine percent of African people have access to electricity and flush toilets compared to 97% for white and Indian people. Access to water is higher among all race groups than access to electricity and flush toilets although significant differences exist among the numbers of people in the different race groups that do have access.⁸

Eighty-five percent of South African households have access to piped water either in their homes, on site or from a communal tap. However 88% of the poorest South Africans do not have access to water in their dwellings. Access to formal housing is restricted to 32% for the poorest South Africans. The most pressing needs for the poorest are access to water in their dwellings, chemical or flush toilets and electricity.⁸

Household access to flushing toilets increased at a national average of only 1% over a five-year period. This figure masks the fact that in some provinces, access to flushing toilets actually decreased, while in others it increased substantially. Three out of the nine provinces registered no change in the number of households that had access to flush toilets. While the national average for households with flush toilets is 52%, in some provinces access is as low as 16%, generally corresponding with other patterns of intra-provincial inequity.⁸

Eighteen percent of the adult population in South Africa has had no formal schooling. Between 1996 and 2001 the number of people with no schooling dropped by 1% from 19% to 18%.⁸

The South African health system

Under the South African Constitution, functions and powers are divided between the three spheres of government: national, provincial and local. Functions may be either exclusive or concurrent in nature. Concurrent functions include health, housing, education and social grants “which do not lend themselves to substantial cost recovery but account for a substantial proportion of public spending”.²¹ The national sphere of government sets the policies and principles by which these services must be delivered. Provinces are mainly responsible for implementation within a nationally determined policy framework.

The South African health system is based on a primary care philosophy. Services provided by primary health care facilities are free although anecdotal evidence suggests that there

is an informal system of user fees being implemented in many rural areas. Services provided by PHC workers include immunisation, communicable and endemic disease prevention and treatment, maternity care, family planning and oral health services. Trained nurses generally treat patients.

Utilisation of PHC facilities stands at 2.3 visits per capita per year, well below the nationally established PHC norm of 3.5. Low utilisation may be an indication of lack of access and/or low acceptability and appropriateness of the services. For example, utilisation is especially low in Mpumalanga Province (1.5 per capita) which has underdeveloped infrastructure; and highest in Western Cape Province (3.8 per capita), which is mostly urbanised and has well established community health centres.⁷

Patients with complications are referred to higher levels of care: district, regional and tertiary hospitals. Telemedicine is starting to be used in the country with varying degrees of success.

A system of user fees based on a sliding scale is in place at hospitals. Free health care is provided to pregnant women, children under six years old and, as of July 2003, to people with disabilities.

The total number of hospitals in the country is 800.²² Up to 399²³ of these are public sector hospitals serving approximately 38 million people while the remaining 20% of the population utilise the remaining 400 hospitals. That there are almost the same number of hospitals serving the public and private sectors is illustrative of the dichotomy between the two sectors.

Provincial disparities exist and are essentially structural in nature, stemming from differential allocation of resources during the apartheid era. Some of the nine provinces incorporate a number of academic complexes, which contribute to health services in a multitude of ways, while others straddle former rural homelands and have not only had to integrate staff and facilities from as many as three different homelands, but also have to provide care in far flung and remote areas.⁷

Health care financing and human resources

The amount of money allocated to the health sector depends on various factors including how much taxation revenue government receives and how the Revenue Allocation Formula is applied to determine allocations to different spheres of government. Within a framework of fiscal federalism, broad policy guidelines are set in place at a national level, but provinces retain authority over how money is spent and allocated within those guidelines.

The provinces and local government have relative autonomy in deciding allocations to the different sectors.²⁴

The vast majority of the revenue collected by government is in the form of company and personal income taxes, and value added tax which is currently set at 14%. In addition to this, certain funds are also ring-fenced for selected priority programmes, replicated at provincial level. Household funding for health care takes the form of medical aid contributions, other forms of private insurance or out-of-pocket expenditures. Employers contribute to health care in the form of medical aid contributions on behalf of their employees, or by providing health care services directly. Donor financing represents a small proportion of overall health care financing although this situation appears to be changing.²⁴

South Africa spends approximately 8% of its GDP on health care. More than half is accounted for by medical schemes.²⁵ This of course means that the actual percentage of GDP spent on health in the public sector is substantially lower. In 2002 South Africa spent 11% of its total budget on health.⁷

The biggest inequality in financing is between public and private health care. Approximately 60% of all South African health care spending goes into private sector, although less than 20% of the population can afford to use private health care regularly. Medical schemes benefits for civil servants comprise a significant public subsidy to the private sector. In 2001/2 average contributions to private medical schemes was approximately R5 900 per beneficiary per year. In contrast the average per capita public health expenditure was R830.⁷

In the public sector, per capita expenditure in the public health system remains inequitable across the nine South African provinces. Current inequities reflect previous patterns of advantage and disadvantage, with historically well-resourced provinces, particularly Gauteng and the Western Cape, having higher spending levels than the previously disadvantaged and predominantly rural provinces of Mpumalanga, Limpopo, North West and the Eastern Cape.

Possibly the most challenging inequity is the maldistribution of health personnel. The private sector, which serves less than 20% of the population, employs the majority of psychologists, pharmacists, dentists, GPs and specialists.

Great disparity also exists *within* the public sector. Wealthier provinces like Gauteng and the Western Cape have 8.9 and 7.8 health workers (in all categories) per 1000 public user population respectively, while the more needy provinces (those that are historically

disadvantaged, poorer and with high rural populations) have less funding for health care services. Mpumalanga, Eastern Cape and Limpopo have 4.1, 4.4 and 4.4 personnel per 1 000 public users respectively.⁷

In 2003, there were 7 645 medical doctors in the public health sector (an increase of almost five percent from the previous year). Nationally, there were 19.7 medical practitioners per 100 000 population. The distribution of these doctors confirms the rural / urban divide with regard to availability of skilled health personnel. For example, in the North West province, the number of doctors per 100 000 population in the public sector is 11.7 – this figure in the Western Cape stands at 31.9. With regard to the racial breakdown of medical practitioners in the public sector, 2 470 are African, 299 coloured, 1 408 are Indian and 3 268 are white, demonstrating again, the degree of discordance in the racial demographics of the country and the number of medically trained doctors in the public sector.²⁵

Tuberculosis in South Africa

According to the South African National Tuberculosis Association, one South African dies from TB every hour.

Recent global TB control efforts have been focused on the 22 high burden countries, which together account for approximately 80% of the world's TB cases. With an estimated 243 000 cases in 2002, South Africa occupied seventh position (from ninth in 2001).²⁶

Table 1: Total estimated cases and incidence for the top ten high burden countries

Rank	Country	Total estimated cases (thousands)	Incidence per 100 000 population
1	India	1 820	178
2	China	1 448	113
3	Indonesia	582	271
4	Bangladesh	328	233
5	Nigeria	275	235
6	Pakistan	247	171
7	South Africa	243	556
8	Philippines	229	297
9	Russian Federation	193	134
10	Ethiopia	188	292

Source: Global TB Report 2003

TB in South Africa disproportionately affects those who were discriminated against under apartheid legislation. As a result, wide variances in tuberculosis incidence, depending on race, were found prior to 1994. Incidence ranged from less than 20/100,000 in the white community to 400-600/100,000 in black and coloured communities.²⁷

KwaZulu-Natal, Eastern Cape and Western Cape have the highest number of cases of TB. These provinces, together with the Northern Cape, also have incidences of TB which are higher than the national average.

Table 2: TB epidemiology in South African provinces

Province	All cases of TB	Incidence per 100 000	% households with monthly income below R800 (1996)*
Eastern Cape	48130	672.3	68%
Free State	14 221	494.0	59%
Gauteng	30 515	373.5	34%
KwaZulu-Natal	52 016	558.8	55%
Limpopo	10 098	172.4	72%
Mpumalanga	6536	205.5	60%
Northern Cape	5642	633.7	50%
North West	17 612	477.8	56%
Western Cape	39 560	917.4	27%
South Africa: 2002	224 420	493.7	

Source: NTCP: Dept. Of Health And * Census 1996:

It has been suggested that the real cause of TB is not the spread of *Mycobacterium* microorganism but the “complex set of socio-economic and political factors outside the realm of human biology”.²⁸ This has a particular resonance in the South African context as the vast majority of sufferers are poor.

Increased probability of becoming infected with TB and of actively developing TB is linked to malnutrition, crowding, poor air circulation and poor sanitation.

TB affects mainly the potentially economically active demographic groups in South Africa. In 1999, for example, 61% of the total reported TB cases were in the age 20-39 age group.²⁹

TB is also concentrated in areas with high unemployment, low household incomes and poor infrastructure availability. The Eastern Cape, which has one of the highest incidences of TB, is also one of the poorest provinces in the country (with an unemployment rate of 55%).

Low PHC utilisation rates is also related to poor detection rates. PHC utilisation rates in KwaZulu-Natal and Eastern Cape stand at 2.3 and 2.0 visits per capita per year respectively. The WHO recommended rate is 3.5 visits per year.⁸

The number of reported cases of TB has risen consistently since inception of the National Tuberculosis Control Programme (NTCP). This is likely to reflect a real increase in the number of cases owing in part to the rising HIV prevalence, as well as improvements in case detection and reporting. A total of 224 420 cases of TB were registered during 2002, an increase of 16% from the previous year. This represents an incidence rate of 494 cases per 100 000 people.²⁶ The Global TB report estimated incidence of 556 per 100 000 people is perhaps more reflective of the true incidence in the population due to under-reporting and less than optimal recording and information systems.

Multi-drug resistant (MDR) TB

A Multi-drug resistant (MDR) TB survey undertaken in eight provinces between 2000 and 2002 revealed that 1.7% of new cases had MDR TB. Although this level is not significantly higher than the global median of 1.1%, the high burden of TB in South Africa means that the country has more MDR TB cases than any other country for which MDR prevalence data is available. However, the Northern Cape which may have an extremely high incidence of MDR TB was not included in the study.²⁶

Several factors are implicated in the increased incidence of drug resistance in TB. These include the irrational use of antibiotics, poor quality anti-TB drugs, poor public health infrastructures, HIV/AIDS, and increasing inequality and poverty.

The Third Global Report on Anti-Tuberculosis Drug Resistance confirms the link between poor programme performance, or insufficient coverage of a good programme, and drug resistance. Thus although treatment of MDR TB remains an important component of overall TB control efforts in South Africa, ensuring adequate treatment of all TB cases must also remain a priority.²⁶

The MDR study also provided information regarding HIV prevalence amongst a random sample of TB patients: 55.3% of cases were found to be HIV-positive. This is slightly lower than the WHO estimate of 60%. Nevertheless it is extremely high and underscores the need for linking TB control and HIV prevention and care initiatives.²⁶

TB and HIV

Globally, levels of HIV and TB co-infection are high and continue to increase rapidly and TB is one of the leading causes of death among people with HIV. UNAIDS and WHO data indicate that one-third of all people with HIV have TB co-infection and that

up to 70% of TB cases are HIV positive. Preventing and treating TB would significantly improve the quality of life of people with HIV, would lead to reduced morbidity and mortality, and would help control the spread of TB.¹⁶

Similarly, Bamford *et al* point out that in South Africa 'the TB epidemic is fuelled by the HIV epidemic. HIV infection is the greatest individual risk factor for TB with both diseases predominantly affecting people in young productive age groups. HIV infection in a person who is already infected with TB increases the risk of developing tuberculosis disease from 10% in a lifetime to 7-8% per year. HIV prevention and integrating HIV and AIDS care is therefore key to controlling the TB epidemic. Pilot projects on integration of TB, HIV/AIDS, and STI services have been established in several districts, and training programmes for joint TB/HIV control activities have been established in each province. As from the 2004/5 financial year, integrated TB/HIV care will be provided in all districts. All TB patients will be offered voluntary testing and counselling, whilst all clients who test HIV-positive will be offered screening and treatment for (or prophylaxis against) TB'.¹⁸

The National TB Control Programme

A revised National Tuberculosis Control Programme (NTCP) was established in 1995, based on the World Health Organization's Directly Observed Therapy Short-course strategy (DOTS) to replace the non-standardised short-course chemotherapy which had been applied throughout the country for several years. It was also decided to provide free medical treatment for people with tuberculosis.

The NTCP has four levels: national level, provincial level, district level and health facility level, all located within the general health services. The national tuberculosis unit plays the role of co-ordination, facilitation and evaluation of tuberculosis services for the whole country. The provincial level is responsible for implementation and budgeting. The district level is the key level for the management of primary health care. The health facility level exists within districts and district hospitals, health centres, dispensaries and clinics are all also found within a district.²⁷

The overall objectives of the National Tuberculosis Control Programme as articulated in the Medium Term Development Plan are:

- to reduce mortality, morbidity and transmission of the disease;
- to reduce human suffering and the social and economic burden on families, communities and the country as a consequence of the disease;
- to establish optimal co-ordination and co-ordinated action with the HIV/AIDS and STD Programme, and
- to prevent the development of drug resistance.

The short-term objectives to be achieved by 2005 include the following:

- to achieve a cure rate of 80-85% among sputum smear-positive tuberculosis cases detected and to reduce the interrupter rate to <10% and the transfer rate to <5%;
- to detect 70% of the estimated new smear-positive tuberculosis TB cases; and
- to achieve DOTS coverage in all districts.

The nine provinces use the Medium Term Development Plan for 2002-2005, as a foundation for their implementation plans.

The following strategies guide the implementation of all control activities:

1. **Integral application of the revised DOTS Strategic Framework of the WHO:**

- sustained political commitment expressed by availing sufficient human and financial resources for achieving the international targets for TB control in the context of the national health system;
- good access to quality-assured tuberculosis sputum microscopy for case detection among persons presenting with symptoms of tuberculosis, screening of individuals with prolonged cough and special attention to case detection among high-risk groups including HIV-infected and institutionalised persons;
- standardised short-course chemotherapy to all cases of tuberculosis under proper case-management conditions including direct observation of treatment (DOT) – proper case-management conditions imply technically sound and socially supportive treatment services;
- uninterrupted supply of quality-assured drugs with reliable drug procurement and distribution systems; and
- recording and reporting systems enabling outcome assessment of each patient and assessment of the overall programme performance.

2. **Partnership building:**

Partnership building between various departments and institutions including other strategic health programmes, laboratory services, health service delivery, academic institutions, private-for-profit health organisations, NGOs, police, correctional services, military services, mines etc. At the international level partnerships are in place with the Belgian government, Centres for Disease Control (CDC), Department for International Development (DFID) International Union Against Tuberculosis and Lung Disease (IUATLD), Royal Netherlands Chemical Society (KNCV), Southern African Development Community (SADC), United States Agency for International Development (USAID) and the WHO.

Nine TB/HIV districts have been established, focusing on facilities that already offered voluntary testing and counselling (VCT) services. VCT was used as a strategic entry point for the package of care.

In 1999, the Accelerated Action against TB was developed. This declaration committed the government to the following targets by 2005:

- a cure rate of 85%;
- treatment interruption rate of 5% or less; and
- a case detection rate of 70%.

In 2000, South Africa participated in an international forum in Cairo to exchange ideas on how the 22 high burden countries would reach their targets. This forum culminated in a commitment to build partnerships and the development of a global DOTS expansion plan.

In 2001, the 22 TB high burden countries committed themselves to the Amsterdam goals and consequently signed the Washington commitment.

According to the national Department of Health, the focus for 2003 was on the development of target-specific Information Education and Communication (IEC) material, addressing stigma, and the development of indicators for TB HIV and monitoring and evaluation tools.

Despite notable policies that have been put in place, real challenges remain to address increased TB case detection and improve cure rates. The Department has identified the following generic challenges that persist:

- the late presentation of patients to facilities;
- late diagnosis of TB by health care workers; and
- the high treatment interruption rates.

Impact of the NTCP

The National TB Directorate has achieved some success in developing and implementing the NTCP. DOTS coverage, for example, has increased substantially, and 182 of the country's 183 sub-districts are now implementing the strategy. In addition, clear TB policies and guidelines are in place, key indicators have been identified and clear targets set. Registers and other key monitoring tools have been developed and implemented. However lack of management capacity, poor management systems, and inadequately trained and motivated staff at a district level has often been cited as the reasons contributing to the failure of the NTCP.^{30,31}

“Despite an impressive array of well-conceived policies, the impact has been less than optimal and varied. Since its establishment in 1996, the NTCP has achieved considerable success in a number of areas. TB control has been identified as a priority at national and provincial levels, standardised policies, guidelines and treatment regimes have been developed, and the DOTS strategy has been implemented throughout the country. The recording and reporting system is well established, with all public health facilities maintaining TB registers and submitting regular reports. This allows the NTCP to identify and provide additional support to districts that are performing poorly. Standardised drugs regimens have been introduced, and considerable effort expended in ensuring regular supply of all TB drugs at PHC level”.²⁶

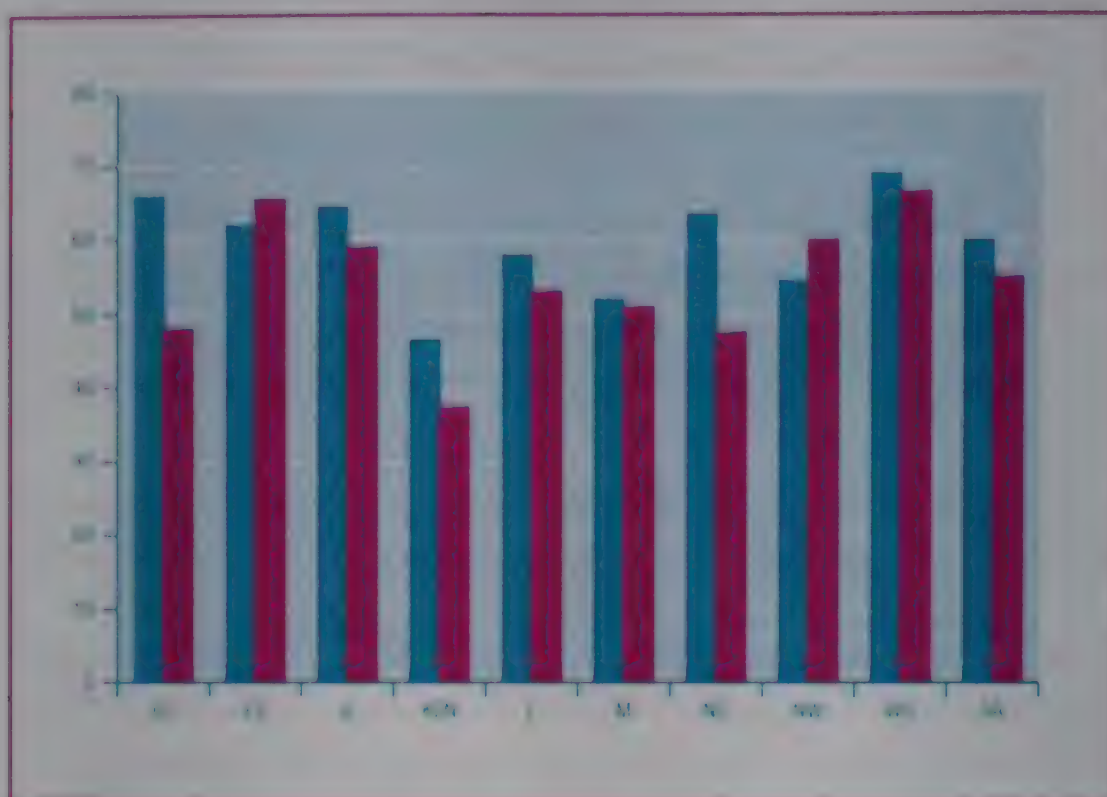
The NTCP has also worked closely with the National Health Laboratory Services and other role players in an effort to ensure adequate access to laboratory services throughout the country. Partnerships have been developed with a range of role players including local NGOs, the academic research community, and other government departments, whilst technical assistance is provided through a number of international agencies such as the WHO, International Union for TB and Lung Disease, the Department for International Development, the Centers for Disease Control and Prevention and the Belgian Government.²⁶

However these improvements in the overall management of the NTCP have not translated into effective control of the TB epidemic. The incidence of TB continues to grow, whilst cure rates remain unacceptably low and treatment interruption rates unacceptably high. The high HIV infection rate in the country is implicated in the increasing incidence and poor cure rates of TB.

Challenges to NTCP

In order to be classified as ‘cured’, patients must be shown to be smear-negative at the end of treatment, whereas ‘successful’ treatment rates include patients who completed their course of treatment, but whose sputa were not examined. Cure rates for new smear-positive patients in all provinces remain well below the WHO (and NTCP) target of 85%. Only 54% of patients were documented to have successfully completed their treatment. The Western Cape achieved the highest cure rate, whilst KwaZulu-Natal performed worst.²⁶

Tuberculosis cure rates by province, 1998 and 2001



Source: National TB Control Programme (NTCP) and DoH

There are various obstacles to effective TB control efforts at district level. The effective functioning of a TB control programme is predicated on there being an appropriate level of commitment and resources in the districts. These include inadequate and inequitably distributed human and financial resources.

Some have pointed out that information about financial allocation to TB control is difficult to find because TB control comes packaged with comprehensive PHC services. It is not known how much time district level managers and health care providers dedicate to TB control. Norms and standards in this regard are unavailable. Management systems at all levels need to be well developed to ensure sound delivery in TB control efforts. However, "a lack of political commitment at provincial level, and the many competing demands placed on health service providers and managers at district and facility level result in TB control efforts often not receiving the priority status they deserve."²⁶

Likewise, there are difficulties in providing Directly Observed Treatment (DOT) in rural areas where treatment supporters are often widely dispersed and poorly supervised. Although small-scale DOT support programmes have proved successful in improving adherence and cure rates such programmes have proved difficult to replicate on a large scale.²⁶

Most TB services are provided by public health facilities. However there are current initiatives to include other service providers formally, most notably the mines who are providing TB services, the private sector (private practitioners, pharmacists, private laboratories) and prisons. Ensuring collaboration with and inclusion of data from these service providers in the recording and reporting system remains a challenge for the NTCP.²⁶ NGO's also provide some TB services. Structural and systemic issues preclude effective execution of what appear to be coherent, efficient policies on paper. Adequate nutrition, for example, is an important component of treatment. In the presence of HIV and TB, adequate food supplies are both preventative in supporting healthy immune systems and curative in that they are essential for drug treatment to be effective and to prevent re-infection. Medical treatment of these diseases risks failure if people are hungry and if they cannot get the right nutrients.³²

According to a recent review on HIV/AIDS and nutrition, wasting and increased nutritional needs were identified as characteristic of HIV and TB, particularly with regard to protein foods and certain vitamins.³² Many people are co-infected with both diseases, and food supplies are therefore a major priority for them. At the same time, most of those infected are among the poorest populations whose immunities are already compromised by lack of food, supplies, sanitation and clean water.

TB and HIV are highly stigmatised diseases and may preclude people from seeking medical care. In addition, since individuals' socio-economic status has been found to determine their access to information about TB and related treatment, it is usually the poor who will not access treatment.

In many cases, HIV/AIDS and TB services exist in parallel resulting in a loss of valuable resources. It is critical that the synergies between HIV/AIDS and TB are exploited by integrating HIV/AIDS and TB services more effectively. However, it is equally crucial that TB does not become subsumed by HIV/AIDS.

The human resources shortage in the country has been well documented. Scarce skills and a lack of personnel to implement TB policies have also contributed to the uneven outcomes of TB control programmes in the country. Allied to this is the shortage and poor capacity of laboratories and related infrastructures that also preclude effective execution of good policies.

The following case study illustrates the constraints and complexities of administering TB control at a district level:

Case Study: Constraints to effective TB Control in Alfred Nzo Sub-District, Eastern Cape

Alfred Nzo Sub-District is one of the poorest of the nine South African provinces. It is one of the poorest districts in the Eastern Cape. As part of the old Transkei it is an extremely poor rural area with limited infrastructure. In the Alfred Nzo Sub-District, Umzimkhulu, Umzimvubu and Maluti. Umzimkhulu is a unique rural district in South Africa and one of the poorest in the Eastern Cape within KwaZulu-Natal.

The Eastern Cape has the highest TB incidence in the country (673 per 100 000). Together with the other eight provinces, the Eastern Cape Province has been designated TB control as a priority. However, because of the six districts that have opted not to implement TB control, there is inadequate monitoring on this issue. However, in the Alfred Nzo Sub-District, Alfred Nzo District is performing very poorly with regard to the key NCTP indicators.

Table 1: Key Indicators for TB control in the Alfred Nzo District, 3rd quarter 2003

Key Indicators	Umzimkhulu	Umzimvubu	Maluti	National Target
Turn Around Time	1 month	3 days +	2 weeks	48 hours
Smear Conversion Rate (%)	50.6	60.8	34	85
Cure Rate (%)	7.5	Not available	45	85
Interruption Rate (%)	3	Not available	Not available	< 5
Clinics experiencing stock outs of key TB drugs in September (%)	5.9	Not available	Not available	0

Source: Maluti: District Information Officer, 1 March 2004
Umzimkhulu: District Information Officer, 1 March 2004
Umzimvubu: CDC, 1 March 2004 (information available does not include Sipetu)

Key Obstacles to Effective TB control efforts in the District

Lack of priority accorded to the NTCP and other health programmes

Although the NTCP is a priority for the DoH in the Eastern Cape, in reality administrative tasks often assume priority. Sub-district officers are based at administrative extensions of the provincial office. Sub-district managers spend up to 75% of their time in the provincial capital attending meetings. Many of the tasks they are expected to attend to when in the sub-districts are administrative and, although considered a priority by the province, have little impact on their core task of implementing TB services and managing the NTCP.

Lack of adequate financial resources

During the demarcation process in 1996 the district of Maluti ceased to exist and was divided between Umzimkhulu and Elundini. However, at the beginning of 2003 provincial politicians decided to recreate the Alfred Nzo sub-district of Maluti. A number of staff who were based in Elundini were moved back to Maluti to form the nucleus of the sub-district management team, but the team was not supplied with financial or material resources to manage and deliver services.

For example, there isn't a single vehicle available to assist in health service delivery within Matutu. This affects the implementation of the NTCP in many ways. Health workers have devised a number of ingenious options to ensure sputum specimens are delivered to the laboratory and adequate drugs are available in the clinics:

- Clinic staff arrive in taxis (public transport) once a month at the sub-district office for a study day. They come to this study day laden with all the sputum specimens collected in their clinics over the last month as well as their drug orders. They return with results for specimens which are available and as many drugs as they can carry on the taxi.
- All patients who attend the clinics are charged a fee of R2.00. This money is used to pay taxi drivers to transport sputum specimens to the laboratory and to collect results.

Although these local attempts to address the transport problems are commendable, other national policies such as free health care services at a PHC level are compromised. The implementation of programmes such as the NTCP is severely compromised.

Lack of an efficient and effective Transport System

Lack of transport within Umzimkhulu sub-district has had considerable negative impact on the NTCP in the area. Although Umzimkhulu has a transport fleet of twelve vehicles, only three are in a working condition. This severely curtailed the collection of sputum specimens from clinics and the travelling of PHC supervisors and the Communicable Disease and TB Co-ordinators to clinics. Recently, when the newest of these vehicles was delivered, the TB Team of the sub-district hoped it would be used for the collection of sputum specimens and clinic supervision.

However in allocating vehicles within the district, administrative functions take priority over programmes such as the NTCP. Within less than 2 months this new vehicle had travelled 22 000 kms, most of these driven by the District Manager as she attends the myriad of meetings to which she is summonsed in the provincial capital 7 hours drive away. The vehicle cannot be sent to the garage for its first service as no other vehicle in the district is considered safe enough for the District Manager to use to travel outside the district.

As a result of transport problems, sputum samples are collected from clinics infrequently. This has considerable implications for the functioning of the NTCP within the sub-district:

- Sputum samples are not taken from suspected cases, so active case finding at a clinic level is minimal or non-existent;
- Infectious TB patients remain undiagnosed, spreading their infection throughout the community;
- Sputum samples are not taken after the intensive phase of treatment, so TB patients cannot be shown to have converted and smear conversion rates are very poor;
- Sputum samples are not taken after the continuation phase of treatment, so the cure of PTB patients cannot be proven, and the best treatment outcome possible is treatment completion.

Poor Clinic Supervision

Clinic supervision is seen by both the National and Eastern Cape Provincial Departments of Health as being of importance for the support of staff and for maintaining quality of care at a clinic level. For the NTCP clinic supervision is essential for providing in-service training, reinforcing training given, ensuring evaluation and support.

- In the Eastern Cape the Primary Health Care (PHC) Co-ordinators and Programme Co-ordinators are expected to supervise clinics. However, few members of the PHC Co-ordinators' team are based in the community, leaving only the provincial and district TB Co-ordinators to supervise.

According to the NTCF and other FHC providers, planned clinic visits are cancelled with alarming frequency. For instance, one day without one supervisor and clinic work.

Availability of resources is often given as a reason for the lack of clinic supervision. This is further reinforced by the fact that at the two points in Lindenberg who should be doing regular supervision only one has a regular income. Thus on any given day a vehicle is often not available and the coordinator have to be contacted by phone to coordinate this kind of irregular visit.

The lack of clinic supervision has severe implications for the NTCF:

- On the functioning of the NTCF as a clinic site
- Supply of the services and supervision of the clinic staff
- Recording and reporting remains incomplete and inaccurate;
- Management of patients is poor;
- Staff are not motivated
- Staff are not supported

Conclusion

The implementation of the NTCF is a sub-optimal and independent on a number of well run management systems including human and material inputs. However, in Alfred Nzo it can be seen that community demands are growing in the area of management and the availability of FHC and TB services for clinic supervision. This constitutes significantly to the future of the NTCF within Alfred Nzo District. Management and staff are responsible for their own activities and to those on their own business of maintaining the NTCF and FHC services.

Source: South African Health Review 2003/4

THE STOP TB PARTNERSHIP

The Stop TB Partnership is a global movement comprising global partnerships to accelerate social and political action to halt the spread of tuberculosis around the world.

It has been suggested that the Partnership was “born from a history of neglect followed by substantial progress marred by failure to achieve the desired goals”.²

Political commitment was identified as the most important reason why TB control failed. Between the mid-1980s and 1990 a 20% increase in global notification rates took place and TB was the leading infectious cause of death.² By 1989, there were only two professional staff dedicated to TB at the Geneva-based WHO; international funding of TB was minimal and very little research was being conducted into the disease. The 1990s saw some progress with 155 out of 210 countries adopting the DOTS strategy.

In 1991, the World Health Assembly set the target of a 70% case detection and 85% cure rate under DOTS for the year 2000. These targets were subsequently converted into targets for 2005.

In 1998 the Stop TB Initiative was launched. This was followed in 1999 by high level support for accelerated action against TB in high burden countries. In 2000 the Amsterdam Ministerial Conference on TB and Sustainable Development pledged to “develop and implement a global partnership agreement through which individuals governments, private organisations and industry could all contribute to efforts against TB”. This was subsequently endorsed by the WHO. The first Stop TB (interim) Co-ordinating Board met in February 2001. It is clear then that “there is no consensus about what constitutes the precise start of the Global Stop TB Partnership. Rather it appears to have evolved over a period of time with key moments in 1998, 2000 and 2001, with most of the formal structures being created in 2001.”²²

The mission of the Stop TB Partnership⁴² is to increase access, security and support to:

- **improve the patient's life** through effective diagnosis, treatment and care to stop transmission of TB
- **reduce the economic toll of TB** and its
- **strengthen and coordinate** with partner(s) diagnosis and therapeutic goals and strategies to Stop TB

The strategic objectives of the Partnership are to:

- **expand DOTS coverage;**
- **scale DOTS** to address the challenge of HIV/TB co-infection and multidrug resistant TB;
- **improve the management** of new and recurrent TB through access and strategies; and to
- **broaden the Partnership.**

Targets have been listed as the following:

- **By 2005, 70% of people with infectious TB will be diagnosed and 85% cured;**
- **By 2010, the global burden of TB (incidence, morbidity and prevalence) will be reduced by 50% compared with 2000 levels;**
- **By 2010, the global incidence of TB deaths will be less than one per million population.**

The following values underlie the Partnership's pursuit of its goals:

- **Urgency:** Urgent action is required to address a situation where nearly two million people continue to die each year from a disease that is curable.
- **Equity:** A reduction of morbidity and mortality requires no-quality treatment and increase susceptibility to infection and disease among vulnerable groups.
- **Shared responsibility:** The elimination of TB is a global public good and a shared responsibility of the global community.
- **Inclusiveness:** All individuals and organizations sharing the Partnership's vision and values are welcomed as members.
- **Cooperation:** The Global Partnership strives to achieve consensus on priorities and best practice, and to act in a co-ordinated way based on the comparative strengths of individual partners.
- **Sustainability:** A key feature of the elimination of TB as a public health problem. As such the Partnership is committed to sustained action and to strengthening national capacity.
- **Dynamism:** As the TB epidemic is constantly evolving, flexibility and continuous innovation is required.

The structure of the Partnership

The Partnership is not a legal entity, but a "group of entities working with a common goal".⁴³ The Stop TB Partnership describes its approach as a co-ordinated, multi-national, multi-sectoral effort to control TB.

The structure of the Partnership includes the Partners' Forum, the Co-ordinating Board, the Secretariat and seven working groups.

A 'partner' is defined as

...either an individual or an entity (government/organisation) that declared with reason(s) and substantiation of the alignment of its goals and values with those from the Partnership and that has expressed interest to become a partners of the Stop TB Partnership.³³

Partnership, then, is seen as an exchange. Partners are intended to give data and feedback, financial or other resources, or strategic inputs (such as marketing, media spots and "influential connections to power brokers"), depending on the partner's particular strengths.³³ In return, the partners are to receive updated information, support and/or referral from other partners, participation in global discussions and a raised profile.³⁴

The Secretariat is housed in the WHO and supports the Partnership and the Co-ordinating Board to carry out communications and advocacy activities and to manage the Global Drug Facility (GDF) and Green Light Committee (GLC).

The *Co-ordinating Board* reflects major constituencies, comprising technical agencies and non-governmental organisations, multi-lateral organisations, geographic regional representatives, countries with a high disease burden, donors and technical working groups.

The GLC and the GDF are two of a number of *Partnership components* that have been formed. They are both procurement mechanisms for TB drugs priced first- and second-line⁴ respectively. By consolidating the market, and partnership with industry, STB has negotiated substantially reduced prices for these drugs. Access to concessionally-priced drugs are linked to a package of application review, technical assistance and monitoring of use by the Partnership.

Access to these procurement mechanisms is also limited by a variety of conditions. To qualify for the GDF drugs (and grants), for example, countries must fall below a threshold GDP per capita of US\$ 3000. Unlike other Stop TB structures the GDF and the GLC are "embedded legal identities housed in the WHO".³⁴

A task force on communication provides co-ordination and formulates communication and advocacy plans for the Partnership. Financial and other resources are administered by a Trust Fund, which reports to the Co-ordinating Board.

⁴ GLC second line TB drugs are for MDR-TB

There are seven working groups.

Those classified as implementation working groups are:

DOTS EXPANSION

TEHY

DOTS PLUS for MDR-TB

Those classified as new tools working groups are:

TE VACCINE RESEARCH AND DEVELOPMENT

TE DIAGNOSTIC RESEARCH AND DEVELOPMENT

TE DRUGS AND RESEARCH AND DEVELOPMENT

Advocacy, Communication, and Social Mobilization (11 April 2004)

THE STOP TB PARTNERSHIP IN SOUTH AFRICA

1 International partners

South African TB control benefits from the technical assistance (TA) and funding of several international agencies who are Stop TB partners.

This section presents a simplified summary of external TA to South African TB control based on key informant interviews with representatives from international STB partners working in South Africa, and work plans obtained from one key informant. It is not intended to be an exhaustive account. TA and funding from international agencies not identifiable as STB Partners is not considered, although such support may be substantial (for example donations by the Belgian Development Aid for collaborative TB/HIV activities). This summary is followed by a discussion of some of the main issues identified by key informants.

Summary of TA from international STB partners

A substantial portion of external technical assistance (TA) is through the TB Coalition for Technical Assistance (TBCTA) mechanism for which KNCV is the lead technical agency and USAID provides most of the funding. The International Union Against Tuberculosis and Lung Disease (IUATLD) is also a substantive partner. Indeed, KNCV, IUATLD and the WHO have a history of technical assistance in South African TB control dating back to the early 1990s.

In addition to the TBCTA mechanism and the partners closely associated with it, DFID supports the NTCP through the secondment of a DFID consultant; it also provides funding to various NGO TB-control projects. Similarly, USAID have seconded technical experts from the CDC and provide funding and mentoring for TB-control NGOs.

International agency support has predominantly been in the following areas:

(i) Contribution to an annual external review of the TB-control programme.

The annual countrywide review started in 1996 and originally involved IUATLD and the WHO in addition to the NTCP. After 2000 KNCV, DFID and CDC have also been involved in this process. The annual review is variously described as a WHO Mission, part of the DOTS Expansion Working Group remit, or a Stop TB activity. It seems that funding and personnel for the mission come from all partners.¹

¹ The annual external review is therefore also considered in the section below on the DOTS Expansion Working Group.



The resulting annual report from this mission is not available in the public domain.

(ii) *Assistance in developing the Medium Term Development Plan for TB control (MTDP) and subsequent Provincial Strategic Plans.*

From the KNCV TBCTA, with consultation from all key national and international partners

(iii) *Activities supporting implementation of the MTDP.* Examples are given in Table 3 below.

Table 3: Examples of TA from international partners for implementation of MTDP

Agency	Activity	Status
CDC / USAID	Establishment and training for standardised, revised TB recording and reporting system with Windows based electronic TB register (all 9 provinces)	All 9 provinces using same reporting system. 3 on Windows based ETR.Net, 6 still to be upgraded.
CDC / USAID	Risk factor studies for treatment defaulting	Unknown
CDC / USAID	Contribution to MDR-TB and TB/HIV surveillance	Unknown
TBCTA / KNCV (+WHO and IUATLD)	<ul style="list-style-type: none"> National training: study tour for two staff members to Indonesia; workshops. Training health care workers International training and conferences 	Ongoing, 2004-05 Ongoing, 2003-05 Ongoing, 2004-05
TBCTA / KNCV (+WHO and IUATLD)	TA for preparation of a national manual by NTCP	Ongoing, 2004-05
TBCTA / KNCV (+WHO and IUATLD)	Operational research projects	Ongoing, 2004-05
TBCTA / KNCV (+WHO and IUATLD)	Monitoring, evaluation and backstopping. Short visits to the country / provinces by KNCV consultant, if required by the program management.	Ongoing, 2004-05
TBCTA / KNCV (+WHO and IUATLD)	Prevalence Survey, Based on the results of the MDR survey in which a very high proportion of suspects were smear positive, the true status of case detection needs to be evaluated. Proposal development and consultation within the Department of Health(DoH) is underway. The DoH will co-ordinate this project with relevant partners such as CDC, KNCV Tuberculosis Foundation and WHO.	Ongoing, 2004-05

Source: Technical agency work plans and key informant interviews

Key themes on TA from international partners

Some respondents suggested that South Africa had a different relationship with international technical assistance (TA) agencies than other sub-Saharan African countries. In the main, there was a sense that South Africa was relatively independent from international assistance. One key informant had this to say:

TB program used to doing things on their own... and in a typically South African way... we don't really rely as heavily on TA from international agencies like other countries do. And the level of technical input here is really minimal to the programme. *Key informant C.*

Related to this observation might be the South African NTCP's concerns about sustainability of externally funded support where provinces contract directly with external funders and donors:

The contract goes to the provinces, we get the reports, but what they do there, we are not consulted; they come with their own ideas, implement, run the project, do not engage the province, management or districts and at the end of the project, they move out and there is no sustainability. A lot of money was spent on TB – but when you look at these provinces, you don't know the impact and now it's even worse off – because when they pulled out no one was left. *Key informant D.*

South Africa doesn't become dependent on donor funding and avoids all the problems that some African countries are finding from this. They have for example little say over which drugs are being used because drugs are donated by somebody. Here it is completely different – the programme funds itself and I think that is the good part, it ensures sustainability. *Key informant C.*

These respondents also expressed a view that external technical agencies cannot solve some of the local technical and operational problems, in particular human resources constraints and political support limits at the provincial level. There was not however general support among informants for the idea of direct budget support.

Further, respondents from external technical agencies were very clear that their approach was not to “develop [their] own agenda”, but rather to respond to NTCP needs and requests, as the NTCP must ultimately “be in charge” [based on comments from respondents G, L and H]. One informant pointed out that in the past Department of Health's capacity to spend money was limited and donors found they could make a bigger, faster impact by spending money themselves “in support of DoH requests” (Respondent G).

The central concern of this report is to ask what impact the Stop TB Partnership has had on international technical assistance (TA) in South Africa. The answer to this question is not clear cut. Firstly, all international agencies operating in South African TB control were active in the country before the initiation of the Stop TB Partnership, and there has been a continuous stream of support since the early 1990s.

The question therefore becomes, what impact has the Stop TB Partnership had on how international partners are operating in South Africa? Has there been a qualitative or quantitative change?

International partners have different responses to this question. At one end of the spectrum, respondents from one technical agency see their work as "purely bilateral" and that "Stop TB has not impacted on [their] role in providing TA (at least not *consciously*)". [Key informant I, *their emphasis*].

From the perspective of those receiving the support:

[TA] has mainly been bilateral... and not necessarily through the Partnership as such... although they [the international technical agencies] are mostly Stop TB Partners... and then, for example, through the TBCTA we have benefited through the Partnership. *Key informant D.*

At the other end of the spectrum is the reported added value that Stop TB Partnership has brought to the KNCVs TA in South Africa.² According to a key informant, the Stop TB Partnership has both qualitatively and quantitatively strengthened the work of the KNCV and helped to reaffirm its goals and bring it credibility. It is responsible for

the co-ordinated way we are now working, avoiding duplications and making use of the additional competencies of each of the partners ... [the STB is also] crucial in identifying and solving new problems such as public private partnership, poverty and TB, TB and children, MDR TB, HIV-TB, Partnerships and Social Mobilisation. everything is being discussed at meetings among all stakeholders. This serves as a kind of peer review... Our partners, acknowledging our expertise on assisting in writing MTDP's, invited us to come to South Africa specifically [to give more TA]. *Key informant L.*

² KNCV are identified here as their singular role in South Africa as "international focal point" for the Stop TB Partnership may be relevant here: "For each high burden country an international focal point has been appointed. Such focal point is a technical agency with extensive experience and that enjoys the trust and constructive collaboration of the NTP and government" [Key Informant M]. See also section on the DEWG below.

The nature of international partner co-ordination helps to explain these divergent responses. South Africa is the only high burden country where no Stop TB Partnership National Inter-Agency Co-ordinating Committee (NICC) has been established. Similarly, no Annual Action Plan has been produced by or for South Africa, defining roles and responsibilities of different partners (as described in the Global Plan to Stop TB. What does exist, as all informants agree, is close co-ordination with the (relatively capable) NTCP by all partners.

There are regular meetings with provincial TB co-ordinators attended by NGOs and international technical people. And problem solving meetings as needed.

Key informant E.

I don't think [the NICC] is applicable here... it is us [NTCP] co-ordinating the financial / technical agencies in the country... *Key informant D.*

In addition to this, some respondents pointed out that the development of an MTDP in a consultative process and offering a framework within which all partners could work, is in itself strong evidence of extra co-ordination facilitated by the Stop TB Partnership.

However, to do justice to the Stop TB Partnership's added value in the co-ordination of TB control, one must look beyond the national level. Annual meetings such as those for the DOTS Expansion Working Group allow partners a forum to discuss TB control in South Africa, and in a reportedly valuable global context. Put differently, partly as a result of the Stop TB Partnership, "the DOTS language is now the universal language of international TB control" [Key informant L].

The NTCP recognises that Stop TB "set the [global] guidelines and then the partners who provide TA stick to what is recommended" [Key informant D]. Further, some respondents suggested that, as STB have raised TB in the global agenda, some even "absolutely bilateral" support for TB control may partially be traced back to STB's efforts.

In summary,

Stop TB has had a huge influence in South Africa, but indirectly and more at the international level, co-ordinating the approach of partners globally. Partners that work with TB control are more likely to work within the DOTS/Amsterdam framework. I think the country [South Africa] sees itself more of a 'partner' than before. *Key informant E.*

2 National partnership

Successive WHO country profiles for South Africa - available from the Stop TB Partnership website - refer to "national partnerships" and "collaborations with national NGOs" in South Africa.³⁵ However, it is important for the purposes of this report to distinguish between two sets of TB collaboration: firstly, national partnerships associated with the Stop TB Partnership, and secondly, more general national partnerships for TB control in South Africa (which include national public-private partnerships).

The Stop TB Partnership has arguably had influence in both these sets of partnerships, as it has potentially contributed to the acceptance of partnership in TB control as a policy norm. Consequently, both the role of Stop TB National Partners and partnerships more generally are considered below.

National STB Partners

The Stop TB Partnership's web-based Partners' Directory lists four "partners from South Africa": three NGOs (TADSA, TB Care Association (1929), and the Nelson Mandela Foundation), and one for-profit corporation (the South African division of the pharmaceutical company Aventis).³⁶

The directors of two NGO partners gave key informant interviews for this report. Both suggested that the Stop TB Partnership has little tangible meaning for national partners in South Africa. Neither of the two organisations has experienced any added value as a result of being a Stop TB partner, in respect of better co-ordination, identification and solving of new problems, goal development, implementation of activities, development of common language with other stakeholders, or increased utilisation of their capacity. Similarly, neither organisation saw the Stop TB Partnership as a source of formal or informal leadership, or was able to describe the Partnership's role in South Africa.

I know we are one of the names on the website as a partner but other than the email newsletter we haven't had any contact with them.... We were invited to a conference in Asia, but were advised it was very high level and might not be any use to us - in any case we couldn't have afforded to go. *Key informant A.*

It has been our experience that these kinds of partnerships (or the idea of them) remain at an almost 'intangible' level. *Key Informant B.*

It is also of note that before the Stop TB Partnership existed, in 1991 and 1994 respectively, both these partners had adopted and were advocating the DOTS strategy (and specifically the DOT component of this strategy). It is not the case then that the DOTS Expansion Working Group has for example profoundly influenced these organisations' strategies, by any direct or indirect mechanism.

These respondents were however positive about the potential role of the Stop TB Partnership, and their involvement within this potential role. Both saw Stop TB as a potential forum for sharing experience and best practice. In addition, they did not identify any problems with the aims of the Stop TB Partnership.

We would partner any initiative that aimed to reduce the burden of TB on the poor.” *Key informant A.*

Aventis South Africa, a for-profit corporation listed as a national partner, was also contacted. However a formal key informant interview was not conducted as Aventis deny being a Stop TB Partner. This is at odds with what appears in the Partners’ Directory and the independent evaluation of the Stop TB Partnership conducted by the Institute for Health Sector Development (and commissioned by the Stop TB Co-ordinating Board), which lists a 15 million donation by Aventis to TB control in South Africa under the heading “Impact on Funding for TB”.²² At time of writing a requested official position statement from Aventis had not been received.

In summary, the Stop TB National Partnership in South Africa, as listed on the Stop TB Partners’ Directory, is not a tangible partnership. Qualification of what constitutes a national partner has been loose enough to allow one organisation possibly to be listed mistakenly as a partner. This suggests a significant discrepancy between official membership policy (see discussion in section ‘Structure of the Stop TB Partnership’ above) and implementation at the national level in South Africa. Upon request for clarification on this issue, the Stop TB Secretariat accepts that no real national partnership exists in South Africa:

As far as we know no steps have been undertaken in the development of a national partnership for RSA. While in other countries, national partners, mostly under guidance or initiative from the NTP, take active interest to transform the rather technical co-ordination of collaborative work into a more inclusive national response. In for example Pakistan, Indonesia and Russia such partnerships are being set up and provide the kind of national platform for all national stakeholders (including the non-traditional ones) to make a meaningful contribution to the fight against TB. Unfortunately this does not yet exist in RSA. *Key informant M.*

Partnerships for TB control in SA more generally

The above does not suggest that no partnerships exist in South Africa which aim to reduce the TB burden. The key informants from South African NGOs both work closely with the Department of Health. Furthermore they described a trend towards increased partnership between themselves and the National TB Control Programme in recent years.

all within the DOTS framework. For example, both NGOs are contracted to support patients being treated by the public health service through DOT, and have been involved in pilot projects identifying ways of funding NGOs involved in TB through the TB control programme.

National level TB NGOs also have direct partnerships with international technical agencies and donors. Examples of such partnerships cited by key informants include funding and operational support from DFID, and funding and 'mentoring' to national NGOs from USAID.

In addition, a partnership project known as the National Coalition Against TB was initiated by the National TB Control Programme in July 2004. Aimed at "scaling up societal support for the fight against TB" the coalition brings together members from the NGO, Corporate, Media and Public sectors.³¹ It is not yet clear how this partnership will operate in terms of goals, definition of partners' roles, and governance.

An important issue for the engagement of NGOs in TB control, recognised by both NGO and other respondents, was the variable quality of services and professionalism provided by TB NGOs in South Africa. Examples were given of NGO representatives being absent at co-ordinating meetings, of NGOs "lacking vision and strategy" and "not keeping up with the times". Capacity is also lacking to regulate these NGOs:

Who cracks the whip? If someone doesn't tow the line ... nobody is able to say 'no more funding for you'... it's frustrating as if we all pulled together we could make a real impact. *Key Informant A*

Allegations of impropriety against the South African National Tuberculosis Association (SANTA) made public a questioning of professionalism in TB NGOs in the country. According to one respondent this controversy "has raised many questions around the government's capacity to monitor contracts with private providers of TB treatment".

There is a sense then that partnership with NGOs is not an automatic panacea in the absence of clear definition of roles, accountability, and capacity to regulate their activities.

Public-private partnerships in South African TB control

A degree of collaboration exists between the National TB Control Programme and the private-for-profit sector in South Africa. Two distinct areas of private sector involvement in public TB control potentially exist.

On the one hand, there are the private health care providers of clinical TB care services. On the other, there is the corporate sector's investment in TB control as a public good,

often described as 'corporate social responsibility' or 'ethical business practice'. Both of these will be considered in turn in the context of TB control in South Africa.

Private-for-profit providers

Only a brief description of the role of private providers in TB care in South Africa is within the scope of this report. The main private-for-profit providers in South Africa are employer-based schemes (especially in mining companies); private general medical practitioners; traditional healers; and private medical laboratories. Some of the overall points about the private-for-profit sector in TB control are:

- *Its role is relatively limited.* The public health sector is predominant in the provision of TB care across South Africa [Key informant F]. It is estimated that only about 5% of TB patients are treated within the private-for-profit sector. This is in contrast to the estimated out-of-pocket private health expenditure in South Africa generally, which is cited at 46%.^d Public TB services in South Africa, it seems, "have a good reputation" [Key informant C].
- *Partnerships are both historical and emerging.* Partnerships between provincial government health departments and employers (in particular the mining industry) providing TB treatment to their workers, are informal and historical. Partnerships between the provincial Departments of Health and private practitioners/hospitals and traditional healers are emerging. [Key Informant F].
- *Partnerships may be increasing in prevalence.* Several respondents reported an increasing engagement of the private sector in TB control.
- *Capacity to regulate is absent.* All respondents asked were clear that the capacity to regulate the private providers was absent, especially at district level.

Uplekar, Pathania and Raviglione³⁸ present three alternative approaches of NTCPs to the threats and opportunities of involvement of the private sector in TB treatment. The first involves promoting a universal public system and legislating against private providers engaging in TB care. The second involves focusing on the public services and allowing the private sector to constitute an independent parallel TB care delivery system. The third option, is to collaborate with the private-for-profit providers, by, for example providing training, supplying TB drugs free of charge, persuading private providers to report TB cases etc.

^d Importantly this figure is cited in documents advocating greater involvement of the private-for-profit sector in TB control, thus potentially and misleadingly overplaying the significance of private practitioners in South African TB control. For example, see Uplekar M, Pathania M, Raviglione M. *Private practitioners and public health work force in tuberculosis control* (Lancet, 2001: 358: 912-16) and *Involving private practitioners in TB control: issues, interventions and emerging policy framework*. TB Strategy and Operations Stop TB Department Communicable Diseases Cluster

Given the variety of private sector actors – from mining company health services to traditional healers – and the autonomy of provincial Departments of Health, it is likely that a mixture of the three approaches outlined by Uplekar *et al* are being exercised in South Africa. For example, arrangements reported by informants included agreements between provincial DoHs and mining companies whereby TB drugs were provided free-of-charge to mines adopting the DOTS strategy (including, importantly, reporting of cases to the DoH).

For private general practitioners, an alternative approach has been adopted which is more of a mix of the second and third strategies described by Uplekar. General private practitioners have largely been ‘left alone’ by the DOH who have instead concentrated on development of the public treatment programme. However, TB drug access is legislatively “restricted to an Essential Drug List...Private Practitioners can access the drugs (through patient prescriptions), but cannot charge patients for treatment”. [Key informant C]

One respondent explains some of the constraints and thinking behind their approach to general private practitioners:

... patients were being charged for services when they are not supposed to be charged. We're not getting proper data from the people who are providing private services. So it's a question of how do we structure it? Do we enter into iService Level Agreements with the providers and how do we monitor it? Obviously there is no capacity at the district... Private Practitioners should not charge for the treatment, but provide support for the patient. We can provide the treatment to them, provided that they then supply the data.

The other option for them is to diagnose and then refer and only act as treatment supporters which means that then treatment will only be given to that individual patient. There could be an arrangement between the provider and the patient on the ‘cost’ of the support...*Key informant D.*

An attempt is being made by the Medical Association of South Africa (MASA) to train their members to provide better TB treatment, including the “rational and advantages of treating TB in the public system” [Key informant C]. The net result is that TB patients are often diagnosed by general private practitioners, and then referred to the public system for treatment.

Corporate social responsibility

The second area of partnership relates to the private-for-profit sector beyond health care providers. Stop TB Partnership documents refer to a broad-based global social movement with actors from a wide variety of sectors. One aspect of this envisaged social movement probably relates to the idea that the corporate sector – beyond health care providers – can, if engaged as a partner, bring health benefits above and beyond what the public sector can achieve by itself.⁵ How exactly this corporate dividend is to be realised at the country level of South Africa is not clear:

I think we might not necessarily fit in with their concept of partnership. We've never really understood what they mean by that... Our partnership is mainly... various initiatives to see how we can engage the private medical sector, for example, the traditional healers, NGOs and so on. *Key Informant D.*

Aside from the mining industry, whose involvement in South Africa has been within the sphere of employer-based medical care, examples of corporate sector 'movement' on TB are not forthcoming.

An exception to this is the €15 million donation by pharmaceutical company Aventis to the Nelson Mandela Aventis Project for TB community health workers, as reported in the independent evaluation of the STB by the Institute for Health Sector Development (IHSD).²² The IHSD report also notes "complex constraints to utilising" the funds in the short term. Two of the key informants also expressed concerns about the effectiveness or appropriateness of this donation:

I'm not sure what they [the community health workers] are going to do. You can't just throw people in like that. [This donation] hasn't been thought through. How is the funding going to reach the people? It creates frustration; it's hard to tell what their plans are. *Key informant A.*

Attempts to ascertain more details about the project from Aventis have at the time of writing been unsuccessful.

Influence on public-private partnerships

We have considered to what extent public-private partnerships have become a policy norm in South African TB control. The question that follows from this is how much influence the promotion of public-private partnership as a global policy norm by the Stop TB Partnership has had in South Africa.

Firstly, there is no doubt that a primary aim of the Stop TB Partnership is to promote public-private partnership in TB control. Article IV of the Amsterdam Declaration³⁹ states:

We commit ourselves to accelerate action against tuberculosis through...
PROMOTING the development of national & international partnerships to stop tuberculosis with all stakeholders in society, including government departments & organizations, private health sector, industry, non-governmental organisations & the community...

There are also a number of mechanisms through which this aim can be advanced. The DOTS Expansion Working Group (DEWG), for example, has the promotion of public-private partnership as a component of its work plan and the South African NTCP, as a member of this working group, is therefore continually exposed to this policy option at annual DEWG meetings, through DEWG publications,⁴ and through DEWG technical assistance. A further example is the booklet entitled "The Power of Partnership", a collection of practical partnership-building guidelines aimed at stimulating the formation of national partnerships, and distributed to the NTCPs of all high burden countries (including SA).⁴⁰

However, while accepting that they have been under the guidance of the Stop TB Partnership, the NTCP sees engagement with the private sector as substantially their own initiative. This is also in a context of a wider endorsement of public-private partnerships by the Department of Health and the Government of South Africa.⁴¹ In addition there are other forces driving any move towards greater public-private partnership in South African TB control:

"This trend [of greater PPP] is mainly driven by a rapidly emerging TB/HIV epidemic, a decline in resources (human resources in particular) available to the public sector, and the strong and resourceful private sector." *Key informant F.*

Indeed, all key informants asked, accepted a need for engagement of the private sector in TB control in South Africa, largely for pragmatic reasons rather than ideological ones.

Thus far only the influence on the Department of Health has been considered. Two examples of private sector involvement that did not directly involve the NTCP, but can be related to the Stop TB Partnership, are also to be found.

The first is a technology transfer agreement between the STB Partner Eli Lilly and South African generic pharmaceutical producer Aspen Pharmacare, for the production of second line TB drugs Cycloserine and Capreomycin.⁴² Lilly is aiming to ensure that these drugs are still available to MDR-TB projects after it withdraws from the market in the near

e Such as the Global DOTS Expansion Plan.

future. It is not clear how this deal relates to TB control in South Africa; the NTCP was not consulted about the transfer. In addition, the South African MDR-TB program uses the anti-tuberculosis agent Tirizadone in preference to Cycloserine and has no plans to change in the future. [Key Informant C].

The second example concerns the development of WHO guidelines for TB control in the work place. This was a joint effort of the International Labour Organisation and Stop TB Partners, especially the World Economic Forum (WEF) and the Open Society Institute (OSI), catalysed by the STB Secretariat in 2002.⁴³ The implementation of these guidelines – for example as a WEF case study in the AngloGold mining company in South Africa⁴⁴ – represents an example of industry regulation stemming from the global level rather than the national government.

In conclusion, the Stop TB Partnership has had an influence on the adoption of public-private partnerships in South African TB control, but this is not readily quantified.

3 Working groups

DOTS Expansion Working Group (DEWG)

It is difficult to define the DEWG. It is not a legal entity, and in many ways could be described as a 'virtual entity'. It includes the national TB programme managers from all 22 high burden countries in its membership, and the international partners. Its primary objective is to meet the global targets of 70% detection of sputum positive (infectious) TB cases, and 85% cure rates for these detected cases under the DOTS framework. These targets were reaffirmed and extended to 2005 at the Amsterdam Summit. Many actors are involved in these objectives, both partners and non-partners.

The DOTS Expansion Working Group (DEWG) is the operational co-ordination component of the Stop TB Partnership with a strong country focus on DOTS Expansion.

Table 4: Objectives / Activities / Indicators for DOTS Expansion Working Group

Activities / Objectives	Specific Activities / Indicators	Example of Annual Budget - 2004 (\$) [†]
1. Technical Assistance:		
Capacity building and human resources development for DOTS implementation	<ul style="list-style-type: none"> • International training courses including training of consultants; • Training material, co-ordination of training • In-service training 	10 000 000
Provision of direct NTP assistance, advisors, missions, and tools	<ul style="list-style-type: none"> • Advisors, missions, and tools • Medium-term plans including budget • Updating country needs and gaps 	35 000 000
Promote engagement of community, private sector	<ul style="list-style-type: none"> • Disseminate examples of policy and experience of engagement of private sector • Public-Private Mix (PPM) Subgroup and Laboratory Capacity Strengthening Subgroup established • Provide guidelines and training for community involvement programmes. 	Not specified in 2004 budget (Subgroup budget under monitoring and reporting below)
2. Support and Co-ordination		
Support and co-ordinate national, regional, and global TB control	<ul style="list-style-type: none"> • Establish Regional and National (all 22 HBCs) Advisory Groups / Inter Agency Co-ordinating Committees, evaluation report in 2004 • Develop Annual Action Plans for all 22 HBCs and Regional Strategic Plans, regularly updated, review for sustainability in 2005 • Updating of plans and budget for agencies (WHO/partners) supporting countries in DOTS expansion - Input to GDEPs • WG missions for evaluation of progress (2000-2003) in all endemic countries in 2004 	Not specified in 2004 budget
3. Monitoring and Reporting		
Monitor and report annually on DOTS expansion and on the progression of TB	<ul style="list-style-type: none"> • Annual DEWG meetings • Publication of DOTS Expansion Reports annually • Subgroups reporting and monitoring - Public-Private Mix (PPM) Subgroup and Laboratory Capacity Strengthening Subgroup, DEWG Core Team etc. 	350 000 20 000 910 000
4. Advocacy		
Activities not specified.		100 000

† Approximate annual budget is based on data for 2004 which is being taken as a rough representation of all 5 years covered in GPSTB. It is therefore meant only as an approximate guide as objectives, activities/indicators are taken from across all five years, not just for 2004. Budget breakdown is based on Pre-Publication Copy of Progress Report on GPSTB (2004).

Source: Adapted from Global Plan to Stop TB and Progress Report on Global Plan to Stop TB

The DEWG has a detailed work plan and projected budget for meeting this work plan, which totals US\$95 million for 2004-2005, with US\$92 million directed at technical assistance over the two years.⁴⁵ This is not, however, a budget that the DEWG, as a distinct legal entity, will ever have central control over, in a centralised bank account. Rather this projected budget is an *estimation* of what all partners should collectively be spending in 2004-05 on DEWG activities.

That is not to say that this projected budget of US\$95 million represents a total cost estimate of DOTS Expansion itself in the world in 2004-05 (this figure is estimated by Stop TB to be US\$ 1.76 billion).⁴⁵ Instead this projected budget refers to a distinct subset of DOTS expansion activities performed by partners (or members) under the heading of the DEWG. At the end of the period 2004-05 there would be no way of determining how much of this budget was realised, short of surveying all the members of the DOTS Expansion Working Group. It can thus be regarded as a *virtual* budget for a *virtual* entity.

This nebulous structure and functioning can be illustrated by relating the DEWG work plan (as summarised in Table 4 below) to activities by partners and DOTS expansion in South Africa.

Overarching the specifics of the work plan is the aim of DOTS expansion as measured by the 85% detection, 70% cure by 2005 target. The NTCP in South Africa had already adopted DOTS as the national strategy in 1996, four years before the Stop TB Partnership was initiated. Because of the substantial autonomy of provincial TB control (and health care generally) this did not automatically translate to DOTS being adopted across South Africa. Indeed, two provinces, as reported by key informants, were highly resistant to DOTS. Hence, as noted by Key Informant L, "in fact South Africa was one of the last countries in the world to accept DOTS." The DEWG therefore did have a major role to play in establishing DOTS as policy in South Africa:

[DEWG has] done a lot for advocacy and getting people to follow a unified approach...and I think in SA in particular that has been the contribution of the DEWG: to say to the government "it's not only WHO advocating the DOTS strategy, it's an international partnership, and that is why it will be doing the right thing to follow that... Because when DOTS was implemented in the country... it was a huge challenge. And especially because it came from WHO there was a lot of resistance.

There is more acceptance of an international partnership like STB than a single agency like WHO... more credibility. *Key informant C.*

In this sense, the DEWG and the STB have achieved something which the NTCP in South Africa could not have achieved by itself, even with the support of the WHO. It is important to note however that the DOTS strategy was not simply a norm set by the Stop TB Partnership and subsequently adopted in South Africa, but was a national norm set by the NTCP (albeit following a WHO / IUATLD review) and later supported by the DEWG.

A more detailed look at how the specifics of the DEWG work plan translate into activities in South Africa is also revealing. The first work plan objective, as shown in table 4, is technical assistance. However,

[...] the DEWG as such is not an entity with direct implementation responsibility. The pivotal point for rallying country support is the multi year DOTS Expansion Plan that clearly outlines the activities and also serves as the resource (human, financial, technical, political etc.) allocation modulator. For each high burden country an international focal point has been appointed. Such focal point is a technical agency with extensive experience and that enjoys the trust and constructive collaboration of the NTP and government. For RSA KNCV... is the focal point. *Key informant M [their emphasis]*

The Global DOTS Expansion Plan, published in 2001, does indeed have a country profile for South Africa.⁴⁴ However this profile does not define the roles of partners in any detail, and gives no mention of the focal point KNCV, for example.

What role the DEWG has in co-ordination of international partners work has already been described above. It is clear from this description that the DEWG proposed budget is not a comprehensive account of all the TA these partners are giving to implement the medium term development plans in South Africa and other high burden countries. Rather, some partners have a dual identity: as an STB Partner and as a bilateral agency [Key informant M]. In the example of KNCV, there is no clear way of defining, through work plans or budgets, what the work of the KNCV is and what the work of the DEWG is. As Key informant L points out, "labels are not important" to the impact of the TA. This does however make any assessment of DEWG technical assistance, as distinct from the continuous stream of TA from bilateral agencies, problematic. The DEWG, as a "virtual entity" has no organisational control or responsibility for the implementation of the DEWG working plan. For example, while the development of a MTDP in each high burden is a specific activity / indicator in the work plan,

... all 22 high burden countries have a medium term development plan that follows the guidelines for such plans as agreed upon during the DEWG meetings.

The actual formulation of the plans is a matter of local and international technical exchanges and support. *Key informant M*

With this major caveat established, some of the other outputs identified in the DEWG work plan can be considered, specifically the annual DEWG meeting, the annual countrywide review (as monitoring and reporting), the establishment of a National Interagency Co-ordinating Committee and Annual Action Plans, and the promotion of public-private partnership.

Annual countrywide review

The annual countrywide review has partially been discussed above (see International partners). Here it is considered in respect of its influence on policy. This influence appears to have been limited. There was some suggestion that there may be tension between the annual review and the NTCP, and that this has presented difficulties for the NTCP:

Every year at the review there is frustration on both ends. The expectations of those that come to visit are not fully realised, because SA is adamant that we know what we are doing... these reviews are done in a short space of time, in various selected stops, there is no way you can get a good sound feeling for what is going on. As a consequence several of the WHO reports have been overly critical and have said, "this is the problem of the SA TB control programme" when in actual fact it is a local problem... *Key informant C.*

It is difficult to analyse this observation objectively, not least because the annual review report is not available in the public domain. On the general topic of reporting one informant did note:

The WHO wants [the NTCP] to provide information on how TB is funded in South Africa. [NTCP] have tried to get this information by asking the provinces to submit information – whatever they could – we failed. We couldn't give... the information. They [WHO] then ask us "but where is the commitment?" – it's very difficult. *Key informant D.*

Overall, there is little evidence in the data collected for this report that the annual review has substantially altered policy:

The impact of such visits concerns mainly technical issues and have not the required scope or depth to be regarded contributable to national control policy." *Key informant M.*

Annual DEWG Meeting

The DEWG meetings have all been attended by members of the NTCP management, who “report on the progress and constraints... and get technical advice on how to overcome certain problems” [Key informant D]. Several respondents commented that bringing together countries facing similar problems was useful. In addition this may provide a mechanism by which concerns can be raised with other global authorities:

“[I]ssues are discussed – and what can be done to solve these problems... the Stop TB Partnership Board can look at options: who can be contacted locally, more partners to try and get some poverty alleviation projects and so on...” *Key informant D.*

However, the key informants were not able to cite an example where this mechanism had influenced policy in South Africa..

NICC and Annual Action Plan

No National Interagency Co-ordinating Committee (NICC) or Annual Action Plans (defining roles and responsibilities of all partners) exist for South Africa. This is another illustration of the absence of operational control or responsibility for the Stop TB Partnership in implementation of DEWG work plans:

The Stop TB Partnership Secretariat only provides generic guidance and support to the partners and countries for setting up such co-ordinating and collaboration mechanism. The initiative actual work must be done by the local stakeholders and not by external influences. *Key informant M.*

DOTS-Plus Working Group for MDR-TB

The DOTS-Plus Working Group was formed by the WHO to respond to a “vicious cycle between health policy and market economics” whereby “a lack of international policy contributes to high drug prices, which, in turn, serve as a primary justification for not implementing projects (to develop policy)”.¹⁷ This logic determined the Working Group’s focus on pilot project implementation and monitoring, and access to second-line TB drugs. The global work plan and budget of the DOTS-Plus Working Group for MDR-TB is summarised in the Table 5 and Table 6 below.

The structure and governance of the Working Group has been characterised by Gupta *et al.*¹⁸ as “an open group of over 50 institutions including academic institutions, civil society organisations, donor agencies, bilateral donors, the for-profit private sector (with

observer status),¹ governments of resource limited countries, and United Nations agencies”; it is convened by the WHO, which also serves as the secretariat. Interestingly, Gupta *et al.* do not mention the Stop TB Partnership Co-ordinating Board in this summary, perhaps to emphasise that the Working Group’s accountability ultimately leads to the internationally representative WHO and World Health Assembly. It does, however, suggest strong WHO ownership of the Working Group.

This is also the case for the Green Light Committee (GLC), formed in 2000 by the WHO as a subgroup of the DOTS-Plus Working Group.⁴⁸ The role of the GLC is to review applications from potential DOTS-Plus pilot projects and determines whether or not they are in compliance with the Guidelines for Establishing DOTS-Plus Pilot Projects for the Management of MDR-TB.⁴⁹ The GLC therefore acts as a gatekeeper for access to the concessionally-priced second-line TB drugs, as negotiated by the Working Group with the pharmaceutical industry.

The Working Group and GLC therefore have the paradoxical aim of decreasing drug costs to improve access but at the same time preventing misuse of these drugs by limiting their availability to GLC supported sites. Again, according to Gupta *et al.*, “[their] response was to consolidate the market and to create a regulatory mechanism [the GLC]”.

South Africa has had a national MDR-TB control strategy since 2000. However, this South African DOTS-Plus project is not associated with the DOTS-Plus Working Group model:

When the government decided to treat MDR-TB there was a policy decision – rightly or wrongly – not to have the pilot sites like they have in other countries: it will be a national program and a NTCP program.... It’s not run by somebody else, it is run as a NTCP activity. *Key Informant C.*

¹ The identities of the Working Group member organisations are not in the public domain (see on the Stop TB Partnership or DOTS-Plus Working Group websites). The key informant interviews for this report confirmed that the pharmaceutical corporation Eli Lilly was represented on the Working Group.

Table 5: Objectives / Activities of DOTS-Plus Working Group

Objectives	Specific Activities
1. Pilot Projects: Initiate and support pilot projects through partner organisations for the diagnosis and treatment of MDR-TB.	<ul style="list-style-type: none"> • Establish pilot sites: support sites previously established • Training sessions and TA for clinical management issues • Continue to revise and improve DOTS-Plus project guidelines • Piloting of new diagnostic tools
2. Drug Access Establish drug access system to provide high quality second-line drugs and prevent their misuse.	<ul style="list-style-type: none"> • This activity developed into the Green Light Committee
3. Monitoring, data & policy Co-ordinate and monitor implementation of DOTS-Plus pilots: assess data and help produce policy recommendations	<ul style="list-style-type: none"> • Pre-approval site visits to projects applying to GLC • Monitoring visits for GLC-approved projects • Co-ordinate operational research studies from projects • Annual meetings of WG • Publication of policy documents / protocols etc
4. Advocacy Advocacy and resource development for new DOTS-Plus projects	<ul style="list-style-type: none"> • Increase visibility of DOTS-Plus efforts: GLC support for pilot projects through press releases and newsletters, documentaries • Increase funding for projects

Source: Adapted from Global Plan to Stop TB and Progress Report on Global Plan to Stop TB

Table 6: 2004 Budget for DOTS-Plus Working Group

Activities	2004 Budget (US\$)
Working Group Co-ordination	
• Annual Working Group Meeting	100 000
• Advocacy and Resource Development	100 000
• Subgroup Meetings (including GLC)	150 000
• Secretariat Support	350 000
Operations	
• Pilot Projects	—
• Training and Technical Assistance	1 500 000
Access System	
• GLC Applications and Monitoring	300 000
Monitoring and Policy Development	
• Data Collection and Analysis	
• Operational Research	1 500 000
• Policy Guidelines and Development	
TOTAL	4 000 000

Source: Taken from Progress Report on Global Plan to Stop TB

Also unlike the Working Group pilot sites, the South African programme receives no external funding. Implementation was contracted out to the South African Medical Research Council (MRC), reportedly to allow the NTCP to focus on continued DOTS expansion:

We need to focus on ordinary TB prevention and control; although we are of course concerned about MDR-TB... we are trying to close the tap on MDR-TB with ordinary DOTS control. *Key informant D*

The MRC will then hand over to the NTCP when the NTCP has the capacity to manage the project.

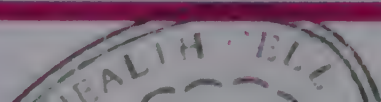
According to one key informant this has also effectively precluded South Africa from applying to the Green Light Committee for access to concessionally-priced drugs. This is despite a pre-GLC-application visit to South Africa in 2002 by the Working Group.

An additional perspective on the withheld GLC application was given in key informant interviews. This related to the drug procurement system in South Africa, whereby drugs are legally registered and tendered centrally by the Department of Health; provinces then order directly from the suppliers. This has two implications for a potential procurement mechanism through the GLC. Firstly, any drugs procured through the GLC would first have to be registered in South Africa. Secondly, as it is provinces that purchase and use drugs (with autonomy from national control), the price reduction that the GLC offered would have substantially increased access to second-line TB unregulated by the NTCP. The implications for public health that this expanded access would have entailed, given that provinces were struggling to implement successful DOTS programmes using first-line drugs, were of primary concern to the NTCP.

Therefore the DOTS-Plus project in South Africa procures second-line TB drugs through the national mechanism. One notable result and example of this autonomy from the GLC is the use of Tirizadone, produced by the national subsidiary of the pharmaceutical corporation Aventis, in place of Cycloserine in MDR-TB regimes. The MRC report a better safety profile for Tirizadone vis-à-vis Cycloserine.

However, a role for the GLC in South Africa may eventually be realised. The MRC is attempting to get the NTCP's DOTS-Plus project registered with the GLC so that in the future, and after hand over, the NTCP can benefit from the GLC's technical input and reviews.

In summary, South Africa's national DOTS-Plus strategy, has eleven MDR-TB treatment centres (at least one in each province) which are independent from the DOTS-Plus Working Group in terms of technical support, drug access, funding or regulation.



DIS-319 p04 08937

The NTCP reports that policy guidelines produced by the Working Group have been useful as an adjunct to domestic guidelines, though they mostly “had to develop our own policy”. Similarly, the Working Group is reported to have been a helpful source of support for surveillance tools, although the details of this support (e.g. budget, outcomes etc.) could not be ascertained for this report. A further activity detailed under objective 3, which the NTCP and South Africa have benefited from, is the annual meeting of the Working Group, which representatives of the NTCP, MRC and provincial sites have attended.

There is a sense that the influence of the Working Group has been relatively informal and irregular (that is to say not the same as for other high burden countries). Three examples from the key informant interviews inform this characterisation.

- (i) The MRC has close links with the Stop TB DOTS-Plus Working Group. This has allowed the MRC to “anticipate and make sure that South African policy complied with guidelines that were in the pipeline from the Working Group” and to “make sure [the MRC] were not advocating anything that would be in conflict” with the Working Group recommendations. This has had “the added benefit of [policy] being endorsed by the Working Group”. [Quotations from Key informant interview]
- (ii) The Working Group has made a visit to South Africa to review MDR-TB control “to see what was going on, but this was not to be on a formal basis”. Nonetheless, this did provide useful feedback to the South African programme.
- (iii) The MRC has presented data to the Working Group, not relating to pilot sites, but relating to issues such as use of Tirizadone (see above) and use of standardised rather than individualised MDR-TB regimes. It is clear then that South Africa is engaged in the Working Group process of developing global policy from operational research.

Finally, one key informant noted that the efforts of the Working Group to add value to global research efforts, for example through the development of a MDR-TB database, has been “invaluable”.

4 Advocacy

The Stop TB Partnership has increased advocacy as a central aim for all its components. In August 2004 advocacy efforts were solidified into a ‘Seventh Working Group for Advocacy, Communication and Social Mobilisation’, although details of membership, budget and work plans are not yet available. Advocacy efforts from the Stop TB Partnership have been for both TB control generally and for the DOTS strategy specifically, often

with little distinction between these potentially distinct areas. Advocacy has been focused at different levels, particularly ministerial or political leaders and at a more societal level (social mobilisation). Although advocacy at these different levels is interrelated, they are considered separately below for simplicity.

Ministerial level

The Amsterdam Meeting in 2000 brought together Ministers of Health and Finance from all 22 high burden countries, and resulted in the Amsterdam Declaration of commitment to TB control in these countries. After this summit the South African Minister of Health gave a press conference to publicise the commitment of the South African Government to TB control. According to Key Informant E, “after the Amsterdam meeting the Minister has been a lot more interested in and supportive of the TB programme”.

What evidence exists of this apparent increased political commitment?

In 2000 the national TB programme team was upgraded into a Directorate and its capacity increased to over 20 people.²² In all nine provinces, TB co-ordinators were appointed. Key Informants interviewed reported an increase in political support for TB control at some level, and all attributed this at least in part to the efforts of the Stop TB Partnership.⁸

People in power are closer to us now. I can pick up the phone and chat to [Chief Medical Officer NTCP], before I could never have spoken to Pretoria like that. *Key informant A.*

The Stop TB Partnerships’ influence in building/strengthening the support of international donors and development agencies for TB control has been discussed earlier. Another example of Stop TB Partnership’s successes at this global advocacy level has been its reported influence in getting TB included on the GFATM remit.

A specific example of the Partnership’s accomplishments in advocating the DOTS strategy, succeeding in getting DOTS accepted in all the relatively autonomous provinces of South Africa, is referred to in the above section on the Dots Expansion Working Group.

In summary, the Stop TB Partnership has successfully increased political commitment to TB control and DOTS at a both national and provincial levels, although this impact is difficult to quantify or disaggregate from other political events.

²² Other reasons expressed were the fall of apartheid, emergence of HIV, and the need to control TB.

Social mobilisation

The precise impact of the Partnership on social mobilisation for TB control and DOTS is also difficult to quantify. Efforts have largely revolved around events such as World TB day and the 'Knock TB for Six' campaign associated with the cricket world cup. Key informants who felt able to comment were generally unenthusiastic about these initiatives. The IHSD independent evaluation reports that the "impact of World TB day, especially in relation to the work that goes into it is being questioned."⁷⁷

It is likely then that social mobilisation efforts have been less successful than political support advocacy, and because of this may be a focus of renewed efforts in the future.

FINDINGS AND RECOMMENDATIONS

The impact of the Stop TB Partnership has been mixed. While there is some evidence of increased political commitment and sustained advocacy initiatives linked to the Partnership, there are many areas where the impact has been less than optimal.

In assessing the impact on how international partners are operating in South Africa, it was found that the Partnership has added value to some technical agencies operating in South Africa. For example, the Partnership has been credited with facilitating a more co-ordinated way of working, avoiding duplications and making use of the additional competencies of each of the partnerships. Some respondents pointed out that the development of an MTDP through a consultative process and offering a framework within which all partners could work, is in itself strong evidence of extra co-ordination facilitated by the Stop TB Partnership.

The independent DOTS-Plus programme has benefited from informal support and communication with the DOTS-Plus Working Group. There are also clear examples of global TB policy norms being advanced in South Africa. Two such examples are the adoption of the DOTS strategy and the emergence of public-private partnerships (PPPs). However the DOTS strategy was accepted by the NTCP as early as 1996, the Partnership's influence has been to lend more credibility to this strategy at the provincial level.

Additionally, the Stop TB Partnership has also been credited with successfully increasing political commitment to TB control and DOTS at both national and provincial levels, although this impact is difficult to quantify or disaggregate from other political events.

The development of generic guidelines has also reportedly been of some assistance to the South African NTCP, as have annual meetings such as those for the DOTS Expansion Working Group which allow partners a forum to discuss TB control in South Africa, in a valuable global context. However, while the South African TB control unit has had some contact with the Partnership – this has been taken place in the context of international meetings with little country level directed support.

Despite the evidence of limited involvement and impact in South Africa, questions remain unanswered as to whether the developments by and work of the NTCP would have taken place without the existence of the Partnership. It is difficult to find a causal relationship between initiatives to control TB in the country and the Stop TB Partnership. This brings us to a pervasive though not explicit theme in this report: TB control is being constrained in South Africa by wider determinants such as human resource deficits.

social inequity and poverty. What impact a partnership of mostly technical agencies can have on these determinants is not obvious to many stakeholders. The potential of partnership with the wider corporate and social sectors has, as yet, not been realised.

The study shows that access to effective diagnosis and treatment and considerations of equity (part of the mission and values of the Partnership) are critical issues in the country and have not been addressed by the Partnership.

This report cites numerous examples and figures of the inequities of South African society, the human resource crisis in the country, the housing and nutritional needs and job creation needs of the country. Until these issues are addressed, TB control will continue to take place in an environment that is hostile and antithetical to an integrated approach to the problem. The limitations of taking a purely biomedical, technical approach to disease control is well documented. The Partnership could potentially play a role in ensuring that global health initiatives extend beyond simplistic 'magic bullet' cures. In addition, the high levels of co-infection of HIV and TB also presents significant challenge to TB control.

Any evaluation of the Stop TB Partnership and indeed other similar GPPs must extend beyond simply what the entity is doing in any given country and critically assess the *impact* of the entity in the country as illustrated by the following quote from one of the key informants:

[...] you know, until you started asking questions about what impact of the Stop TB Partnership in South Africa was, I hadn't really thought about it – it was then that I realised that I can't really tell you what they have done in the country. I also started thinking about what is the difference between the WHO and the Stop TB Partnership. Where does one begin and where does the other end?

The following recommendations to the Partnership are pertinent:

Rights-based approach

A rights-based approach to the problem must be adopted which includes the active meaningful and free participation of individuals who are affected by the issue. Any attempt to curb, control and treat TB must recognise the disease as a social, economic and political one and not purely a medical problem. In this regard, the Stop TB Partnership should work towards creating relationships with various stakeholders and not just with governmental agencies and departments and a few selected NGOs.

The link between public health and human rights has sometimes been tenuous. Human rights were considered as perhaps antagonistic to public health issues because the latter was considered to promote the “collective health of society even if individual freedoms were curtailed, such as through quarantine and excessive institutionalisation”.²⁸ This has changed over the past few decades as people have come to accept the potentially reinforcing and synergistic relationship between the two.

The indivisibility and interdependence of health and human rights is now commonly accepted. It is understood as being critical to the development and achievement of human potential. However, many of the rights now codified and protected in international and national legal instruments are now under threat owing to aggressive globalisation, deepening inequities and a general malaise regarding the broader issues of poverty and underdevelopment in our world.

In this context, it is important that GPPs do not simply address only the health problems that are in fact symptomatic of deeper, systemic issues in our world. For the right to health to become meaningful, it is crucial that the factors that operate outside the health system are also addressed.

Effective TB control and treatment efforts will not survive or flourish in an environment where insufficient attention is paid to the broader underlying socio-economic determinants of health. Some of the structural factors that contribute to the flourishing of the disease include poverty and economic underdevelopment which is frequently expressed in inequities and uneven health outcomes. A development approach to addressing TB would then seek to address system-related factors that underline general ill health such and poverty and gender inequities.

Transparency and Visibility

Although the Stop TB Partnership has a central website, it was very difficult to obtain information on the partnership at country level. Detailed knowledge of the Partnership seems to be confined to a few key people. Several relevant documents are not in the public domain. Further, many of the respondents were not clear what the Stop TB Partnership is. Common misunderstandings include that the perception that the Partnership is a funding agency like the GFATM; is an organisation that directly implements TB programmes; or that it is simply the WHO by another name.

Although the partnership has support at national government level, politicians who are considered to be co-drivers of policy are not well informed about the aims and objectives and the activities that underpin the Partnership. This gap has the potential to weaken the

Partnership and must be addressed.

"I don't know about the Stop TB Partnership and I have been on the Portfolio Committee for nine years, what is it?"^h

"The Stop TB Partnership? To be honest I have never heard of them. The TB directorate have never mentioned them in their briefings to us as a Committee."

There was however greater awareness amongst politicians about the work of the Global Fund, partly because the committee was addressed by the Secretary of the Global Fund and has received regular briefings on the progress the Global Fund has made by the National Department of Health. This has given rise to parliamentary debates and questions on the Global Fund and its activities.

An appropriate response to TB constitutes more than just procuring drugs and upgrading existing infrastructure. A complex set of geopolitical, medical, social and financial factors need to be aligned to produce a fair, sustainable and humanitarian response.

^h Member of the National Assembly Portfolio Committee on Health, National Parliament.

ⁱ Member the Portfolio Committee on Health, National Parliament

REFERENCES

- 1 Labonte R, Schrecker T, Sanders D, Meeus W (2004) *Fatal Indifference – the G8 Africa and Global Health*. University of Cape Town Press and IDRC
- 2 Kumaresan J, Heitkamp P, Smith L, Billo N *Global Partnership to Stop TB: a model of effective public health partnership*. Intl Journal of Tuberculosis and Lung Disease 8(1) 120-129
- 3 Buse K, Walt G (2000) *Global public-private partnerships: part 1 – a new development in health?* Bulletin of the World Health Organisation, 2000, 78(4)
- 4 Buse K, Waxman A, *Public-private partnerships: a strategy for WHO*. Bulletin of the World Health Organisation, 2001, 79 (8) 748-753
- 5 Widdus R *Public-private partnerships for health require thoughtful evaluation*. Bulletin of the World Health Organisation, 2003, 81 (4)
- 6 Buse K. *Governing Public-Private Infectious Disease Partnerships*. The Brown Journal of World Affairs Winter/Spring 2004 Volume X Issue 2
- 7 Ntuli A, Ijumba P, McCoy D et al (2003) *HIV/AIDS and Health Sector Responses in South Africa; Treatment Access and Equity: Balancing the Act*, Equinet Discussion Paper 7, EQUINET
- 8 Khosa S, Ntuli A, Padarath A (2004) *The Second Equity Gauge*. Durban: Health Systems Trust
- 9 United Nations Human Development Report 2003 <http://www.undp.org/hdr2003/indicator/ctyfZAF.html>
- 10 International Covenant on Economic, Social, Economic and Cultural Rights. 1996
- 11 Republic of South Africa, Constitution of South Africa, Act 108 of 1996
- 12 General Comment No. 14 of UN Committee of ESCR, 200, para 34-37
- 13 South African Human Rights Commission (2003) *The right to health*
- 14 Ray S, Kureya T (2003) *Zimbabwe's Challenge: Equity in Health Sector Responses to HIV and AIDS in Zimbabwe* Equinet Discussion Paper 9, EQUINET
- 15 McCoy D (2003) *Health Sector Responses to HIV/AIDS and Treatment Access in southern Africa: Addressing equity*, Equinet Discussion Paper 10, EQUINET
- 16 Stewart R, Padarath A (2004) *Providing Antiretroviral Treatment in Southern Africa – A Literature Review*. Durban Health Systems Trust.
- 17 Bradshaw D, Nannan N. *Health Status* In Ijumba P, Day C, Ntuli A, editors. South African Health Review 2003/04. Durban Health Systems Trust.
- 18 Bradshaw D, Groenewald P, Laubscher R et al. *Initial estimates from the South African National Burden of Disease Study, 2000*. MRC Policy Brief: 1. March 2003. URL: <http://www.mrc.ac.za/policybriefs/initialestimates.pdf>

- 19 Day C, Gray A *Health and Related Indicators* In In Ijumba P, Ntuli A, Barron P, editors. South African Health Review 2002. Durban: Health Systems Trust.
- 20 Policy Co-ordination and Advisory Services, The Presidency (2003) *Towards a Ten Year Review – A synthesis report on implementation of government programmes*.
- 21 2003 Intergovernmental Fiscal Review. National Treasury Republic of South Africa 2003
- 22 Institute for Health Sector Development (2003) *Independent External Evaluation of the Global Stop TB Partnership*. Institute for Health Sector Development: London.
- 23 Indicators Database available on www.hst.org.za
- 24 Hickey A, Van Zyl, A (2002) *South African budget guide and dictionary*. Cape Town. Idas
- 25 PERSAL Personnel Administration System – extracted 2003-19-30
- 26 Bamford L, Loveday M, Sabine Verkruyl SI (2004) *Tuberculosis* In Ijumba P, Day C, Ntuli A editors. South African Health Review 2003-04. Durban: Health Systems Trust.
- 27 Department of Health (2001) Medium Term Development Plan 2002-2005
- 28 Stop TB Partnership Secretariat *Guidelines for Social Mobilisation : A human rights approach to TB* Geneva www.stoptb.org
- 29 Kironde S (2000) *Tuberculosis* In Ntuli A, Crisp N, Clarke E, Barron P (eds) South African Health Review 2000. Durban : Health Systems Trust
- 30 Kironde S, Bamford LJ. Tuberculosis. In Ijumba P, Ntuli A, Barron P, editor. South African Health Review 2002. Durban: Health Systems Trust. <http://www.hst.org.za/>
- 31 Hausler H, Rowe K, Makhubele B, Pronkyk P, et al Providing care in South Africa – Lesson from TB/HIV pilot districts. February 2002 Insight Health Issue No. 2 URL: <http://www.id21.org/insights/insights-h02/insights-iss02-art03.html>
- 32 International HIV/AIDS Alliance Improving access to HIV/AIDS related treatment, International HIV/AIDS Alliance. <http://www.aidsalliance.org>
- 33 Partners to Stop TB: Criteria for selecting, classifying and accepting partners. DRAFT. Stop TB Partnership. Co-ordinating Board, Osaka, 19-21 February 2002. Accessed 14 August 2004 at http://www.stoptb.org/ coordinatingboard/19Feb_Osaka_Partners_to_Stop_TB.doc The final version is not available in the public domain.
- 34 World Health Organization. Global TB Drug Facility: A global mechanism to ensure uninterrupted access to quality TB drugs for DOTS implementation. WHO, CDS/STB/2001.10. Geneva, Switzerland: WHO, 2001.
- 35 Country Profile: South Africa. In World Health Organisation. Global Tuberculosis Control Surveillance, Planning, Financing. WHO Report 2002. Geneva, Switzerland. Pp 109.
- 36 Partners' Directory: Partners from South Africa. Accessed July 10, 2000, from <http://www.stoptb.org/partners/default.asp?country=ZA>
- 37 Coalition against TB gears up against scourge. Accessed 20th August 2004 from <http://www.doh.gov.za/docs/news/2004/nz0712.html>

- 38 Uplekar M, Pathania M, Raviglione M. Private practitioners and public health: weak links in tuberculosis control. *Lancet*, 2001, 358: 912-16
- 39 Amsterdam Declaration to Stop TB. 24 March 2000, Amsterdam, The Netherlands. Accessed July 23 2004 at <http://www.stoptb.org/conference/decla.pdf>. See also the Global Plan to Stop Tuberculosis, pp 145.
- 40 New publication – Building national partnerships. Communiqué, Issue 36, October 2003. Accessed 20 August, 2004 at <http://www.hopkins-tb.org/stoptb/>
- 41 Public/Private Partnerships in Health: National Department of Health Policy Framework. National Department of Health, Pretoria, 2000. Note: this document is not in the public domain.
- 42 Progress of Lilly MDR-TB Partnership Highlighted as Part of World TB Day. Eli Lilly and Company, Corporate News Release, March 24, 2004. Accessed 22 August 2004 at http://newsroom.lilly.com/news/Corporate/2004-03-24_lillyprogress_worldtbdays.html
- 43 Stop TB Partnership Secretariat 2002 Achievements Summary. Accessed 24 August 2004 at www.stoptb.org/coordinatingboard/3April'03_Brasilia/CB_Brasilia_Secretariat_Activity_Report2002.pdf
- 44 Global Health Initiative: Private Sector Intervention: Case Example: Detecting active tuberculosis (TB) cases, with 88% of cases being cured or completing treatment, for less than US\$ 85 per employee per year. World Economic Forum, Geneva, 2002. Accessed 22 August 2004 at http://www.weforum.org/pdf/Initiatives/GHI_TB_CaseStudy_AngloGold.pdf
- 45 Progress Report on Global Plan to Stop Tuberculosis, World Health Organisation, Geneva, 2004. Annex 6.
- 46 Global DOTS Expansion Plan: Progress in TB control in High Burden Countries, 2001. World Health Organisation, 2001. Accessed 14th July 2004 at http://www.stoptb.org/Working_Groups/DOTSExpansion/CountryProfiles.pdf . Pp26-7.
- 47 Gupta R, Kim JY, Espinal MA, Caudron JM, Pecoul B, Farmer PE, Raviglione MC. Responding to market failures in tuberculosis control. *Science*, 2001; 293: 1049-51.
- 48 Gupta R, Cegielski JP, Espinal MA, Henkens M, Kim JY *et al*. Increasing transparency in partnerships for health – introducing the Green Light Committee. *Tropical Medicine and International Health*, 2002; 7: 970-76.
- 49 DOTS-Plus and the Green Light Committee. World Health Organisation, 2000. Accessed 10th July 2004, at <http://www.who.int/gtb/policyrd/PDF/DOTSGLC.pdf>





HEALTH
SYSTEMS
TRUST

401 Maritime House
Salmon Grove
Victoria Embankment
Durban
South Africa

Tel: +27-31-3072954
Fax: +27-31-3040775
Email: hst@hst.org.za
Internet: www.hst.org.za